WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01300

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 211 Arch Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 211 Arch Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Harry E. Alderton

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Ellen Edwards

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28, 1866

8. AGE: Years	Months	Days	If less than one day
73	11	1	hrs. min.

9. Birthplace: Allegany County, Maryland (Town, county, and state)

10. Usual occupation: Retired, Tie Plant

11. Industry or business: Railroad

FATHER 12. Name: Peter Alderton

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Martha Ingram

MOTHER 15. Birthplace: Maryland

16. Informant: Harry W. Alderton

Address: 211 Arch St., Cumberland, Md.

17. Burial (Burial), cremation, or removal. Which?) Date thereof March 3, 1940 (month) (day) (year)

Cemetery or crematory: Oldtown Cemetery

Location: Oldtown, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Mar. 4, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 29, 1940, at 4.35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25, 1940, to Feb. 29, 1940, and that I last saw h~~e~~ alive on Feb. 29, 1940

	DURATION
Immediate cause of death: Lobar Pneumonia	2/22/40
Uraemia	2/29/40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Clay E. Jarrett M. D. or other

Address: Cumberland, Md. Date signed 3/1/40

RECEIVED
MAR 6 1940
BUREAU Y. S.

Outside of City Limits

01301

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Bedford Road, R. F. D. #3
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Bedford Road, R. F. D. #3
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry Fenton Askey

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Abbie Bertha Askey
6(c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.): November 3, 1869

8. AGE: Years 70 | Months 3 | Days 13 | If less than one day ___ hrs. ___ min.

9. Birthplace: Lockhave, Lycoming Co., Penna. (Town, county, and state)
10. Usual occupation: Contractor (Retired)
11. Industry or business: Lumbering

FATHER
12. Name: Samuel Askey
13. Birthplace: Shoeshoe, Penna.

MOTHER
14. Maiden name: Helen Mickler
15. Birthplace: Bethelem, Penna.

16. Informant: Mrs. Helen Gilpin
Address: R. F. D. #3, Bedford Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 18, 1940 (month) (day) (year)
Cemetery or crematory: Zion Memorial Cem.
Location: Bedford Road, R. F. D. #3

18. Funeral director: Jacob Hafer
Address: Cumberland, Md.

19. Feb. 17, 1940 (Date rec'd by registrar) J.P.Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1940 12:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 19__ to ___ 19__, and that I last saw him alive on 1937 or later? 19__

Immediate cause of death: Found dead in bed — Chronic myocarditis — DURATION 3 yrs.
Due to
Due to
Other conditions: Had a cerebral hemorrhage in 1937 and never recovered
(Include pregnancy within 3 months of death)
Major findings: Chronic nephritis 4 yrs.
Of operations
Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. W. Trevaskis, M. D. M. D. or other
Address Cumberland, Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (157-2)

01302 9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ____ County ____
City or town ____ Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME: Baby Atkinson

3. (b) Social Security Number: None

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: —
6 (b) Name of husband or wife: —
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Feb 5 1940

8. AGE: Years — Months — Days — If less than one day: 9 hrs. 25 min.

9. Birthplace: Frostburg - Alleg - Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Henry Atkinson
13. Birthplace: Frostburg Md

MOTHER
14. Maiden name: Viola Merrel
15. Birthplace: Midlothian, Md.

16. Informant: Henry Atkinson
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 6-1940 (month) (day) (year)
Cemetery ~~or crematory~~: Allegany
Location: Frostburg
18. Funeral director: J. J. Durst
Address: Frostburg

19. Feb 6th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 1940, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1940 to Feb 5 1940, and that I last saw him alive on Feb 5 1940.

Immediate cause of death: Congenital Heart — DURATION: 9 hrs 25 min
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: W. O. McLane Jr. M. D. or other
Address: Frostburg Md. Date signed: Feb 6 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

01303

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town BARTON Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(o) IF VETERAN, NAME WAR

3. (a) FULL NAME LUCY AYERS, MRS.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(o) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

B (b) Name of husband or wife EZEKIAL AYERS

B(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) APRIL 1 1884

8. AGE:

Years	Months	Days	If less than one day
56	10	7	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER

12. Name FREDERICK HYDE

13. Birthplace MARYLAND

MOTHER

14. Maiden name MARY SHUGARS

15. Birthplace MARYLAND

16. Informant Ezekial Ayers.

Address Frostburg Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Feb. 4. 1940 (month) (day) (year)

Cemetery or crematory ~~Mount Hill~~ Laurel Hill.

Location Frostburg Md.

18. Funeral director David S. Boal.

Address Barton.

19. Feb. 9. 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr Jacobson.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 8 1940 9:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1940, to Feb 8 1940, and that I last saw h[er] alive on Feb 8 1940.

	DURATION
Immediate cause of death Diabetes Coma	1 day
Due to Diabetes Mellitus	? ?
Due to	
Other conditions Myocardial disease	?

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M. D. or other

Address 119 Bedford St. Date signed 2/9/40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

CERTIFICATE OF DEATH

01394

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 65 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 725 Maryland, Avenue
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Annie Elizabeth Beall

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Lessington Beall
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1874

8. AGE: Years	Months	Days	If less than one day
65	5	7	hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: George C. Smith
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Meisel
15. Birthplace: Germany

16. Informant: Vernon Beall
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22, 1940 (month) (day) (year)
Cemetery or crematory: Greenmont Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Feb. 22, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

Dr. Koon

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19, 1940, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16, 1940, to Feb. 19, 1940, and that I last saw h- alive on Feb 19, 1940.

	DURATION
Immediate cause of death: Diabetic Coma	2 Days
Due to: Diabetic Mellitus	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hobart A. Forman M. D. or other
Address: Cumberland Md Date signed

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

01305

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 648 Baker St.

Stay in hospital or inst. (yrs., or mos., or days) 2 wks

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Penna. County Fulton

City or town Near Hancock, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rural
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Etta Beatty

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isaac Beatty

6(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Febru Sept. 22, 1879

8. AGE: Years 60 | Months 4 | Days 12 | If less than one day ___ hrs. ___ min.

9. Birthplace Shanks, W. Va.
(Town, county, and state)

10. Usual occupation Housewife at Homes

11. Industry or business On Farm

FATHER
12. Name Stephen Hannas
13. Birthplace W. Va.

MOTHER
14. Maiden name Margaret Carter Hannas
15. Birthplace W. Va.

16. Informant Marvin Hannas
Address 648 Baker St.

17. Burial & Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 7, 1940 (month) (day) (year)

Cemetery or crematory Ebenezer Cem

Location Ebenezer, W. Va.

18. Funeral director W. H. McKee
Address Augusta, W. Va.

19. Feb. 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1940, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1940, to February 4 1940, and that I last saw her alive on February 19

Immediate cause of death: Myocarditis

DURATION: 2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Johnson Jr. M. D. or other

Address Cumberland, Md Date signed 2-6-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01308

9

108

1. PLACE OF DEATH

County Allegany Registration Dist. No.

Village or City Frostburg Miners Hosp No. Frostburg Md St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where daath occurred ...yrs...mos...ds. How long in U. S. if of foreign birth? ...yrs...mos...ds.

2. FULL NAME BABY CECIL BITTINGER If U. S. Veteran, specify WAR

(a) Residence: No. JENNINGS. MD. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	W.	Single

5a. If marriad, widowad, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day, end yaar) ~~Dec.~~ Dec. 5 1939 ~~1940~~

7. AGE Yaars	Months	Deys	If LESS than 1 day, ...hrs. or ...min.
	1	30	

OCCUPATION

8. Trada, profassion, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc. —

10. Date daceasad last workad at this occupetion (month and year) —

11. Total tima (yaars) spant in this occupation —

12. BIRTHPLACE (city or town) (Stata or country) Jennings md

FATHER

13. NAME Floyd Bittinger

14. BIRTHPLACE (city or town) (State or country) Jennings md.

MOTHER

15. MAIDEN NAME Celia Friel

16. BIRTHPLACE (city or town) (Stata or country) Jennings md

17. INFORMANT (Address) Floyd Bittinger Jennings md.

18. BURIAL, CREMATION, OR REMOVAL Place Jennings md Date Feb. 5, 1940

19. UNDERTAKER Floyd Bittinger, Father (Address) Jennings md.

20. FILED 2-5, 1940 mrs. A R. Walker Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH FEB (Month) 4 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 2/2/40, 19..., to 2/4/40, 19...

I last saw him alive on 2/3/40, 19...; death is said to have occurrad on the date stated above, at 1:30 A m.

The PRINCIPAL CAUSE OF DEATH and ralated ceuses of importance were as follows:

	Date of onset
Pneumonia	
(Lobar)	

Other Contributory Ceuses of importanca:

Name of operation ... Date of ...

What test confirmed diagnosis? Exam Was there an autopsy? ...

23. If death was due to axternal causes (VIOLENCE) fill in also the following:

Accidant, suicida, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Spacify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Natura of injury ...

24. Was disease or injury in any way ralated to occupation of dacaased? ...

If so, spacify ...

(Signad) John Kilday, M.D. M. D.

(Addrass) 56 W. Main Street.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriasclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

01307

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
306 Maryland Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County Somerset Co.

City or town Fairhope Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR ✓

3. (a) FULL NAME Owen Brady

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Malinda Sophia Brady ✓

6(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Dec 11 1852

8. AGE:

Years	Months	Days	If less than one day
87	1	22	____ hrs. ____ min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Plasterer

11. Industry or business Building industry

FATHER
12. Name Patrick Brady ✓
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Fitzpatrick
15. Birthplace Ireland

16. Informant Minnie Eck

Address Fairhope, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1940 (month) (day) (year)

Cemetery or crematory Hyndman Cemetery

Location Hyndman, Pa

18. Funeral director Jacob Hafer

Address 320 Baltimore Ave.

19. Feb. 4, 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

Dr. Soon

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30 1940, to Feb 3 1940, and that I last saw him alive on Feb. 2 1940

Immediate cause of death	DURATION
Organic Heart Disease, Chronic Endo Carditis & Chronic nephritis	3 yrs
Due to Bronchial asthma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward N. Brown M. D. or other

Address Cumberland Md Date signed Feb 4 1940

CEIVED
MAR 6 1940
REAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

01308

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution 530 Woodside Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 530 Woodside Ave.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna Bell Brashears

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

B (b) Name of husband or wife Isaac Brashears

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1861

8. AGE:

Years	Months	Days	If less than one day
78	11	17	hrs. min.

8. Birthplace Flintstone Allegany, Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home

FATHER 12. Name Henry Bucy

13. Birthplace Town Creek, Md.

MOTHER 14. Maiden name Annie Bell

15. Birthplace Allegany County, Md.

16. Informant Mrs Edmund B. Duff

Address 26 - 5th St - Cumberland Md.

17. Burial Date thereof Feb 29, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Jacob Hafer

Address Cumberland Md.

19 Feb 29 1940 J. L. Franklin, M. D.
(Date rec'd by registrar) Registrar

Dr Trevaskis

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/40 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1940 to 2/27/40 and that I last saw h alive on Feb 14 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION 2 weeks

Due to

Due to

Other conditions Myocarditis — DURATION 2 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. N. Trevaskis M.D.
M. D. or other

Address Cumberland Md Date signed 2/28/40

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

01309

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: McCoole
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 32 Howard St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: McCoole Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 32 Howard St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Wilbur Raymond Brewer

3. (b) Social Security Number: 705-05-1716

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Nellie(Dayton) Brewer
6(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): May. 4, 1892

8. AGE: Years	Months	Days	If less than one day
47	9	6	hrs. min.

9. Birthplace: , W. Va.
(Town, county, and state)
10. Usual occupation: B. & O.Ry. Conductor
11. Industry or business: B. & O. Ry. Co.

FATHER
12. Name: L.S.Brewer
13. Birthplace: W.Va.

MOTHER
14. Maiden name: Jennie Iser
15. Birthplace: Md.

16. Informant: Mrs. Nellie Brewer
Address: McCoole, Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb.13/40 (month) (day) (year)
Cemetery or crematory: Dayton Cemetery
Location: Allegany Co. near McCoole, Md.

18. Funeral director: J.H.Markwood Sons
Address: Keyser, W.Va.

19. Feb. 12 1940 (Date rec'd by registrar) A.J.Baynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8 1940, to Feb. 10 1940, and that I last saw h- m- alive on Feb 10 1940.

Immediate cause of death: Pulmonary Tuber. — DURATION: 3 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: T.C. Giffin M.D. M. D. or other
Address: Keyser W.Va. Date signed 2-12-40

RECEIVED
MAR 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

01310

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) about 1/2 hr.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garrett

City or town near Accident Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry Myers Broadwater

3. (b) Social Security Number 219-03-8852

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 6-13-1898

8. AGE: Years 41 | Months 7 | Days 23 | If less than one day ____ hrs. ____ min.

9. Birthplace Myrell Garrett Co Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name James Broadwater

13. Birthplace New Germany Garrett Co

MOTHER

14. Maiden name Old Road

15. Birthplace Jonaconing Allegany Co Md

16. Informant Mildred Yaklety

Address Accident Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-9-1940 (month) (day) (year)

Cemetery or crematory New Germany M. E. Cemetary

Location Rural Near Grantsville

18. Funeral director Wm Winebrenner

Address Grantsville Md

19. Feb. 8, 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1940, at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1940, to Feb 5 1940, and that I last saw h[illegible] alive on Feb 5 1940.

Immediate cause of death: Internal Hemorrhage — DURATION

Due to Crushed Pelvis

Caught between coal truck & house

Due to Back broken

as above

Other conditions Injured at 7:50 a.m.

died at 7:50 a.m.

(Include pregnancy within 3 months of death)

Major findings:

Of operations Was going to help nephew unload coal from truck. Emergency brake became unloosed, truck ran forward and caught him between truck & house.

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 2-5-40

Where did injury occur? Potomac Park (City or town) Allegany (County) Md (State)

near Cumberland Md

Injured at home, farm, industry, public place (where?) Nephews home

Means of injury Caught between coal truck & house Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address 67 N. Centre St Date signed 2-5-1940

Cumberland, Md

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CB

01311

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 24 Washington St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County

City or town Sharon Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 266 Orchard Ave.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Daniel Brode

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Amelia Brode

6(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Jan 13 1860

8. AGE: Years 80 Months X Days 25 If less than one day ——— hrs. ——— min.

9. Birthplace Frostburg, Md
(Town, county, and state)

10. Usual occupation Foundry

11. Industry or business Steel industry

FATHER
12. Name Daniel Brode
13. Birthplace Germany

MOTHER
14. Maiden name Minnie Miller
15. Birthplace Germany

16. Informant Hattie Brode

Address 24 Washington St - Frostburg, Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Feb 11, 1940
(month) (day) (year)

Cemetery or crematory Oakwood Cemetery

Location Sharon, Pa.

18. Funeral director Jacob Hofer

Address 230 Baltimore Ave.

19 Feb. 10th 1940 Mrs. A. R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Feb 9 1940, and that I last saw him alive on Feb 6 1940.

Immediate cause of death Arterio Sclerosis

DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane Jr. MD
M. D. or other

Address Frostburg Md Date signed Feb 10 1940

McLane.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(I)

RECEIVED
MAR 2 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

01312

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County Allegany

City or town Cumberland RD #1

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Long, Md

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 24 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Long Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #1 Cumberland, Md

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edgar Wm. Bryner

3. (b) Social Security Number 214-07-0793

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marion Long Bryner

6(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Feb 7 1885

8. AGE: Years 55 Months 0 Days 11 If less than one day hrs. min.

9. Birthplace Connellsville, Pa. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Rubber Tire Co.

FATHER 12. Name Wm. D. Bryner

FATHER 13. Birthplace Connellsville, Pa

MOTHER 14. Maiden name Lydia Shaw

MOTHER 15. Birthplace Connellsville, Pa,

16. Informant Mrs. Marion Bryner

Address Long, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 15, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md

18. Funeral director Jacob Hafer

Address 230 Baltimore Ave

19. Feb 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

J. P. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1940, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1939 to Feb 13 1940, and that I last saw h. alive on February 6 1940.

Immediate cause of death Coronary Occlusion — DURATION Feb 13, 1940

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T Johnson M. D. or other

Address Cumberland Md Date signed 2-14-40

RECEIVED
MAR 8 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH 01313

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH (8)

County Allegany Registration Dist. No. 4

Village or City Cumberland Md No. 23 N. Lee St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Infant Bucy

(a) Residence: No. 23 N. Lee St. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, end year): February 12 1940

7. AGE: Years ... Months Stillborn Days ... If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Cumberland Md.

FATHER

13. NAME: Walter Montgomery Bucy

14. BIRTHPLACE (city or town) (State or country): Keiser W. Va.

MOTHER

15. MAIDEN NAME: Elva May Kerr

16. BIRTHPLACE (city or town) (State or country): Davis W. Va.

17. INFORMANT: Mrs. Walter Bucy

(Address) 23 No. Lee St. City

18. ~~BURIAL~~, CREMATION, OR ~~REMOVAL~~

Place Home Date Feb. 13, 1940

19. UNDERTAKER: Parente

(Address) 23 N. Lee St.

20. FILED Feb. 14, 1940 J. P. Franklin, M.D.

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 12 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1940, to Feb 12, 1940

I last saw him alive on Stillborn, 19...; death is said to have occurred on the date stated above, at 11:45 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Intrauterine Asphyxia	2-12-40
Other Contributory Causes of importance: Premature labor (4 mo. gestation)	2-12-40

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of Injury ...

Nature of Injury ...

24. Wes disease or injury in eny wey related to occupation of deceesed? ...

If so, specify ...

(Signed) Arthur T. Jones M. D.

(Address) Arthur T. Jones

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (8)

01314

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: Allegany Hosp.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Flintstone Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Bucy

3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) February 2, 1940
8. AGE: Years Months Days If less than one day Stillborn hrs. min.
9. Birthplace Cumberland, Allegany, Md (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Edward Lewis Bucy
13. Birthplace Luke, Md.
MOTHER 14. Maiden name Betty Marie Chaney
15. Birthplace Flintstone, Md
16. Informant Edward L. Bucy
Address Flintstone, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1940 (month) (day) (year)
Cemetery or crematory Bucy Cem, Private
Location Flintstone, Md
18. Funeral director Edward L. Bucy - Parent
Address Flintstone, Md
19. Feb. 2, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1940, at 3 45 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 1940, to Feb. 2 1940, and that I last saw him alive on Feb. 2 1940.
Immediate cause of death Suffocation during version & extraction.
Due to
Due to Occiput posterior - difficult forceps - impossible to deliver thus.
Other conditions
(Include pregnancy within 3 months of death)
Major findings: —
Of operations
Of autopsy —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE W. Royce Hodges, M.D. M. D. or other
Address Cumberland, Md Date signed 2/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 — 1315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 223 Avirett Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Paul A Byrne — Paul A. Byrne
3. (b) Social Security Number: 712-14-1545

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 4, 1888

8. AGE:

Years	Months	Days	If less than one day
52	0	21	hrs. min.

9. Birthplace: Ocean, Maryland (Town, county, and state)
10. Usual occupation: Brakeman
11. Industry or business: C. & P. Railroad

FATHER
12. Name: Timothy Byrne
13. Birthplace: Ireland

MOTHER
14. Maiden name: Sarah Cullen
15. Birthplace: Ireland

16. Informant: Miles J. Byrne
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 27, 1940 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery
Location: Frostburg, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19 Feb 27 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-25-40 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-24-40 19 ____, to ____ 19 ____, and that I last saw h[illegible] alive on 2-28-40 19 ____.

Immediate cause of death: Ruptured Gastric Ulcer — Lobar Pneumonia — DURATION: 2 weeks 3 days

Due to:

Due to:

Other conditions: Coroners

(Include pregnancy within 3 months of death)

Major findings:
Ot operations:
Ot autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed: 2-29-40

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131-8)

Reg. Dist. No. 9

01316

WITHIN CORPORATE LIMIT

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 18 Centennial St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 28

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 18 Centennial St (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Nettie Carder

3 (b) If veteran, name war —

3 (c) Social Security No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James Carder

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1862

8. AGE: Years 77 Months 4 Days 29 If less than one day hr. min.

9. Birthplace Avilton, Allegany, Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Morgan Robinson

13. Birthplace Borden Mines, Md

MOTHER 14. Maiden Name Rose Ann Findley

15. Birthplace Somerset County, Pa.

16 (a) Informant James Edward Carder

(b) Address 30 Green St Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14, 1940 (month) (day) (year)

(c) Cemetery or crematory St Michaels Cemetery

Location Frostburg Md

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg Md

19 (a) Feb. 14-40 (Date rec'd by registrar) (b) Mrs. J. R. Hafer Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 12 1940 at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1940, to Feb. 12 1940, and that I last saw him alive on Feb. 12 1940.

Immediate cause of death Chronic Myocarditis. Chronic nephritis. Due to arterio sclerosis.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none.

Of autopsy

Duration: 5 yrs. 5 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. C. Diehl, M.D. M. D. or other

Address Frostburg, Md. Date signed 2/12/40.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 2 1910
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

01317

9

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 14 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland Ward No.: 5 (If outside city or town limits, write RURAL NEAR and give town)

Street No.: (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Anna Elsie Eaton

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Thomas Eaton

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): — — 1858

8. AGE:

Years	Months	Days	If less than one day
81	—	—	hrs. min.

9. Birthplace: Midland, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER

12. Name: James Elsie

13. Birthplace: Scotland

MOTHER

14. Maiden name: Unknown

15. Birthplace: Scotland

16. Informant: Mr. Hugh Watson

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 5 1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: Mr. Eichhorn

Address: Lonaconing, Md.

19. Feb. 3rd 1940 (Date rec'd by registrar) Mrs. A. P. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2 1940, at 11 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 31 — 1940, to Feb 2 1940, and that I last saw h alive on Feb 2 1940.

	DURATION
Immediate cause of death: Gangrene both feet	??
Due to: Arterio Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. D. M. Lane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: Feb 3 1940

RECEIVED
MAR 2 1942
BUREAU V. S.

01318

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Allegany Registration Dist. No. 6

Village or City Westernport No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred 1 yrs. 6 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ray Mayberry Chambers If U. S. Veteran, specify WAR

(a) Residence: No. 56 Arch St St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	White	Single

5a. If married, widowad, or divorcad HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and yaar) Nov. 19 1907

7. AGE	Yaars	Months	Days	If LESS than 1 day, hrs. or min.
	32	2	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Invalid

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Martinsburg (State or country) W. Va.

FATHER

13. NAME Calvin K. Chambers.

14. BIRTHPLACE (city or town) Martinsburg (State or country) W. Va.

MOTHER

15. MAIDEN NAME Annie M. Sanders

16. BIRTHPLACE (city or town) Pa. (State or country)

17. INFORMANT Francis Chambers (Address) Westernport. Md

18. BURIAL, CREMATION, OR REMOVAL Place Martinsburg W. Va. Date Feb. 10, 1940

19. UNDERTAKER W. H. Friddock (Address) Piedmont W. Va

20. FILED Feb. 8, 1940 Paynhaker M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. 8 (Month) (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1939, to Feb 8, 1940

I last saw him alive on Feb 8, 1940; death is said to have occurred on the data stated above, at 4 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance ware as follows:

	Date of onset
Pulmonary Tuberculosis	1935
Bronchial occlusion	Feb 1-40
Othar Contributory Causes of importance:	
asthma	Feb. 6-40

Name of operation None Data of —

Whet test confirmed diagnosis? Exam. Was thara an autopsy? No

23. If deeth was dua to external causes (VIOLENCE) fill in also the following:

Accidant, suicida, or homicide? Dato of Injury, 19

Whara did Injury occur? (Specify city or town, county and State)

Specify whather injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Natura of Injury

24. Was disaase or injury in any way related to occupetion of deceased? no

If so, spacify

(Signed) F. Berry M. D.

(Address) Piedmont W. Va

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

MAR 4 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

01319

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 332 Baltimore Ave
Stay in hospital or inst. (yrs., or mos., or days) 70 years
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 332 Baltimore Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ---

3. (a) FULL NAME Cornelius Connor Chandler
Cornelius C. Chandler

3. (b) Social Security Number 705-09-9774

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Augusta Yager
6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) January 21, 1870

8. AGE:

Years	Months	Days	If less than one day
70	0	17	---- hrs. ---- min.

9. Birthplace Cumberland, Alle, Maryland
(Town, county, and state)
10. Usual occupation Sheet Metal Worker
11. Industry or business B. & O. Railroad
FATHER 12. Name Thmoas H. Chandler
13. Birthplace Maryland
MOTHER 14. Maiden name Amanda Connor
15. Birthplace Maryland
16. Informant Mrs. Harry Rice
Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 10, 1940 (month) (day) (year)
Cemetery or crematory St. Luke Cemetery
Location Cumberland, Maryland
18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. Feb. 10, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1940, at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1 1934, to Feb 7 1940, and that I last saw him alive on Feb 6 1940

Immediate cause of death	DURATION
Cardiac dilatation	2 months
Due to Chronic Bronchial asthma	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D.
M. D. or other
Address 67 N. Centre St Date signed 2-7-40
Cumberland Md

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01320

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Murleys Branch

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Arthur Selby Christie

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida Zimmerly

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1861

8. AGE:

Years	Months	Days	If less than one day
78	8	5	hrs. min.

9. Birthplace Near Cumberland, Md. (Town, county, and state)

10. Usual occupation Road Supervisor, Retired

11. Industry or business County

FATHER

12. Name Robt. Christie

13. Birthplace Maryland

MOTHER

14. Maiden name Jane Selby

15. Birthplace Maryland

16. Informant Mrs. Thomas Long

Address North Branch, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 24, 1940 (month) (day) (year)

Cemetery or crematory Davis Memorial Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. Feb. 24, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. Jacobson

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1940, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1940, to Feb. 21 1940, and that I last saw h in alive on Feb. 21 1940.

Immediate cause of death Uremia and myocardial failure

Due to Angiolas Fibrillation

Mitral Stenosis & insufficiency

~~Due to~~ Hypertension

Chronic Nephritis

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

?

0

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel M Jacobson MD M. D. ~~or other~~

Address 119 Bedford St Date signed 2/23/40

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87)

CERTIFICATE OF DEATH

01321

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hosp.
Stay in hospital or inst. (yrs., or mos., or days): 6 days
Stay in this community (yrs., or mos., or days): 14 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 110 So. Johnson St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Miss Peggy L. Clayton

3. (b) Social Security Number: None

4. Sex	5. Color or race	6(a) Single, married, widowed, or divorced
F	White	Single

8 (b) Name of husband or wife: —
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 31 - 1925

8. AGE: Years: 14 | Months: 5 | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business: Public School

FATHER
12. Name: George Clayton
13. Birthplace: West Va

MOTHER
14. Maiden name: Ethel Peters
15. Birthplace: West Va

16. Informant: George Clayton
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-26-40 (month) (day) (year)
Cemetery or crematory: Rose Memorial Park
Location: Cumberland Md
18. Funeral director: V. L. Lemmerand
Address: Cumberland, Md.

19. Feb 26, 1940 (Date rec'd by registrar) J. P. Buckley M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23, 1940, at 4a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5, 1940, to Feb 23, 1940, and that I last saw h[illegible] alive on Feb 23, 1940.

Immediate cause of death	DURATION
Acute mastoiditis (left)	Since Feb 1st 1940
Extra-dural abscess	
Due to Acute otitis media left	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Acute mastoiditis (left) Extradural abscess
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Cyrus R. Everhart M. D. or other
Address: 36 Greene St Date signed: 2/26-40

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

01322

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 days

Stay in this community (yrs., or mos., or days) 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 406 Oldtown Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Blanche Clem

3. (b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced ~~Wit~~ Divorced

8 (b) Name of husband or wife William Dilly

6(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 28, 1884

8. AGE: Years 55 Months 6 Days 4 If less than one day ___ hrs. ___ min.

9. Birthplace Horseshoe Run, W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Private home

FATHER
12. Name Robert E. L. Breedlove
13. Birthplace New Market, Va.

MOTHER
14. Maiden name Alma J. Sell
15. Birthplace Horseshoe Run, W. Va.

16. Informant Robert Clem

Address Cresaptown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1940 (month) (day) (year)

Cemetery or crematory Texas Cemetery

Location Preston Co., W. Va.

18. Funeral director Jacob Hafer

Address 230 Baltimore Ave

19. Feb. 4 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Dr. Lanich

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1940, at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1940, to Feb 2 1940, and that I last saw her alive on Feb 1 1940.

Immediate cause of death Lobar Pneumonia Type III

Due to ✓

Due to ✓

Other conditions none

(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓

Of autopsy ✓

DURATION 7 days

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. J. Lanich M.D.
M. D. or other

Address Cumberland Md Date signed 1-4-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4 — 21323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Wills Creek

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Mineral

City or town: West Virginia Ward No.: Ridgely (If outside city or town limits, write RURAL NEAR and give town)

Street No.: (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR: World War ✓

3. (a) FULL NAME: George F. Coleman

3. (b) Social Security Number: None Known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years	Months	Days	If less than one day
42			hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: George W. Coleman

13. Birthplace: Bedford, Penna.

MOTHER — 14. Maiden name: Laura V. Lance

15. Birthplace: Bedford, Penna.

16. Informant: Albert Coleman

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 23, 1940 (month) (day) (year)

Cemetery or crematory: Sumner Cemetery

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Feb. 22 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20th., 1940 at about 10.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19__, to 19__, and that I last saw h__ alive on 19__.

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: none

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 2/20/40

Where did injury occur? Cumberland, (City or town) Allegany, (County) Maryland. (State)

Injured at home, farm, industry, public place (where?): Wills Creek.

Means of injury: fall into creek Injured at work? no

23. SIGNATURE: Prince H. Booth M.D.

Address: Cumberland, Maryland M. D. or other

Date signed: 2/21/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
FEB 29 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01324

Reg. Diat. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County allegany

City or town Dawson (rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
R.F.D. #3 Keyser, W. Va.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 mo 11 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Dawson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. # 3, Keyser, W. Va.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Linda Lou Coleman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1940

8. AGE: Years	Months	Days	If less than one day
0	1	11	hrs. min.

9. Birthplace Dawson, Allegany, W. Va.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name David Franklin Coleman
13. Birthplace Lonaconing, Md.

MOTHER
14. Maiden name Alice Mae Ross
15. Birthplace Lonaconing, Md.

16. Informant David Franklin Coleman
Address R#3 Keyser, W. Va.

17. burial Date thereof Feb. 22, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Totten Cemetery

Location Lonaconing, Md.

18. Funeral director N. H. Rogers

Address Keyser, W. Va.

19. Feb. 21 1940 A. Baynhaker M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1940, at 3.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1940 to Feb. 18 1940 and that I last saw her alive on Feb. 18 1940

Immediate cause of death	DURATION
Congenital Debility	1-9-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Courrier M.D.
M. D. or other

Address Keyser W. Va. Date signed 2-20-40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95-C

01325

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Church Hill ~~Residence on Yellow Road~~

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 68 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Residence on ~~Yellow Road~~ Church Hill (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Ellen Conway

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1871

8. AGE: Years	Months	Days	If less than one day
68	7	13	hrs. min.

9. Birthplace: Mt. Savage, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER
12. Name: Peter Conway
13. Birthplace: Mt. Savage, Md.

MOTHER
14. Maiden name: Jane Barrett
15. Birthplace: Mt. Savage, Md.

16. Informant: Frank Conway
Address: Mt; Savage, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Feb. 4, 1940 (month) (day) (year)

Cemetery or crematory: St. Patrick Cemetery

Location: Mtl Savage, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Feb 3 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

8;20p

20. DATE OF DEATH: Feb. 2, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw her alive on May 1939.

Immediate cause of death: Sudden Death, most probably —

Due to: Acute Dilatation of Heart

Due to: Exact form of cardiac affection not known. C.W.G.R.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. J. Bostetter M.D. M. D. or other

Address: Mt Savage Md Date signed: 2/3-40

RECEIVED
MAR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63E

CERTIFICATE OF DEATH

01326

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 23 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town BARTON Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME FLORA COOLING

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife GILBERT C. COOLING
6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 14, 1885

8. AGE: Years	Months	Days	If less than one day
54	2	19	hrs. min.

9. Birthplace PHILADELPHIA, PA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name WALTER MASLIN
13. Birthplace ENGLAND

MOTHER
14. Maiden name MARY OGBORN
15. Birthplace Unknown

16. Informant G. C. Cooling
Address Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6. 1940 (month) (day) (year)
Cemetery or crematory Laurel Hill
Location Mogeon Md.

18. Funeral director David S. Boal
Address Barton, Md.

19. Feb. 5, 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 3 1940, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jany 12 1940 to Feby 3. 1940, and that I last saw h[illegible] alive on Feby 3. 1940.

Immediate cause of death Hypothyroidism
Late Case Partly Acetylic
Extreme emaciation & Prate
Due to 70 + — So Called
Resistant Thyroid,
Due to
Other conditions Incidental Hypertyrosis —

(Include pregnancy within 3 months of death)

Major findings of operation Emaciation — Highly Toxic
Thyroid Thyroid Cyst
Of autopsy No.

DURATION: 2 yrs, 4 mos, 3 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other
Address [illegible] Date signed [illegible]

FEB 19 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-a

CERTIFICATE OF DEATH

01327

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 11 DAYS
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town FRIENDSVILLE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME MRS. GRACE COVER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SEPARATED

6 (b) Name of husband or wife JAMES COVER

6(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 24, 1902

8. AGE: Years	Months	Days	If less than one day
37	11	13	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

FATHER
12. Name JEREMIAH CASTEEL
13. Birthplace Unknown

MOTHER
14. Maiden name MARTHA SMITH
15. Birthplace MARYLAND

16. Informant Memorial Hosp.
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10, 1940 (month) (day) (year)
Cemetery or crematory Steel Cem.
Location Friendsville, Md

18. Funeral director W. W. Savage
Address Friendsville, Md

19. Feb. 9, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 7, 1940 at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27, 1940, to Feb 7, 1940, and that I last saw h alive on Feb 7, 1940.

Immediate cause of death	DURATION
a Exhaustion	
Due to Cancer Uterus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. A. Grant M. D. or other
Address Cumberland Date signed 2/9-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01328

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 219 Pennsylvania Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 219 Pennsylvania Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles F. Craze

3. (b) Social Security Number: 220-10-9237

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

B (b) Name of husband or wife: Ruth Welker
Craze Peabody 6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 15, 1906

8. AGE: Years	Months	Days	If less than one day
33	4	12	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Potomac Edison
11. Industry or business: Operator

FATHER
12. Name: Robert L. Craze
13. Birthplace: Maryland

MOTHER
14. Maiden name: Clementine Beuciage
15. Birthplace: Maryland

16. Informant: Mrs. Leona Rank
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 29, 1940 (month) (day) (year)
Cemetery or crematory: Old Coney Cemetery
Location: Lonoconing, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Feb. 29 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. M. E. B. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1940, at 7½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940, to Feb 27 1940, and that I last saw alive on Feb 26 1940.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	about 2 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. E. B. Owens M. D. or other
Address: 33 Va Ave Date signed: Feb 29 1940

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

01329

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 233 Maryland Ave. Westernport Md

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Francis Cross

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Maidekuck Cross

6(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) August 15 1864

8. AGE:

Years	Months	Days	If less than one day
75	5	25	hrs. min.

9. Birthplace Lithuania (Town, county and state)

10. Usual occupation Common Laborer

11. Industry or business Pulp & Paper Mill

FATHER 12. Name Peter Cross

13. Birthplace Lithuania

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant John Cross

Address 233 Maryland Ave. Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 15, 1940 (month) (day) (year)

Cemetery or crematory St. Peters Cemetery

Location Westernport, Md.

18. Funeral director D. L. Daly

Address Barton, Md.

19. Feb 15 1940 (Date rec'd by registrar) J. Baynebaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1940, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6 1940, to Feb. 13 1940, and that I last saw h[illegible] alive on Feb. 13 1940.

	DURATION
Immediate cause of death Cerebral Hemorrhage	2/13/40
Due to Arteriosclerosis	1930
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P E Berry M.D.

M.D. or other

Address Piedmont WVa Date signed 3/14/40

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

01330

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 95 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Isabella Jane Crowe

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William Crowe

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 6 1844

8. AGE: Years 95 | Months 7 | Days 26 | If less than one day ____ hrs. ____ min.

9. Birthplace Mt Savage Allegany Co Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

MOTHER

12. Name Robert Graham

13. Birthplace Scotland

14. Maiden name Jane Mairs

FATHER

15. Birthplace Scotland

16. Informant Edward Griffin Faugh

Address Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1940
(month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Mt Savage Md

18. Funeral director W. E. Durst

Address Frostburg Md.

19. Feb 4 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2nd 1940, at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1939 to Feb 2nd 1940 and that I last saw her alive on Feb 1st 1940

Immediate cause of death Influenza — DURATION 4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D.
M. D. or other

Address Mt Savage Md Date signed 2/4/40

RECEIVED
MAR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

01331

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Mt. Savage

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Old Row

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 71 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Mt. Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Old Row

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emma "Stokes" Crowe

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6 (b) Name of husband or wife Frank Crowe

6(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) March 3 - 1868

8. AGE:

Years	Months	Days	If less than one day
71	11	5	____ hrs. ____ min.

9. Birthplace Mt. Savage Allegany, Md (Town, county, and state)

10. Usual occupation Home work

11. Industry or business At Home

FATHER 12. Name Benjamin Franklin Stokes

13. Birthplace Maine

MOTHER 14. Maiden name Sarah Sloan

15. Birthplace Md

16. Informant Mrs Elsie Grimes

Address Zihlman Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 11, 1940 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Mt. Savage Md

16. Funeral director Jacob Hafer

Address Frostburg Md

19. 2/9 1940 W J Bostetter MD

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1940, at 9:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1939 to Feb. 8 1940

and that I last saw h er alive on Feb 1 1940

Immediate cause of death	DURATION
Acute Dilatation of Heart	
Due to Auricular fibrillation	
Chronic myocarditis	8 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W J Bostetter M. D.

M. D. or other

Address Mt Savage Md Date signed 2/9-40

RECEIVED
MAR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-E)

01332

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Hoffman, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Margaret Davis

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1903

8. AGE: Years 36 | Months 7 | Days 14 | If less than one day hrs. min.

9. Birthplace Vale Summit, Allegany, Md.
(Town, county, and state)

10. Usual occupation Textile dept (Retired June 1934)

11. Industry or business Celanese Corp.

FATHER 12. Name Henry Davis

13. Birthplace Hoffman, Md.

MOTHER 14. Maiden name Margaret Huggins

15. Birthplace Vale Summit, Md.

16. Informant Rhea Corrigan

Address Acosta, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25 1940 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg, Md.

18. Funeral director Jacob Hoffer

Address Frostburg, Md.

19. Feb 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Van Orner

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1940, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 - 1940 19 , to Feb. 22 1940, and that I last saw h 22 alive on Feb 22 1940.

Immediate cause of death Rheumatic Heart Disease — DURATION 2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Orner M. D. or other

Address 40 N. Liberty St. Cumberland Md Date signed 2-25-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

01333

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121) UB

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 Weeks

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Va. County: Mineral

City or town: Ridgely Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Miller Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Mrs. Ethel Mae Dawson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: King E. Dawson

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 30, 1883

8. AGE:

Years	Months	Days	If less than one day
56	2	29	____ hrs. ____ min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Robert Dayton
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Florence Ridgely
15. Birthplace: W. Va.

16. Informant: Mr. King E. Dawson
Address: Miller Road, Ridgely, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 2, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. March 1, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 29, 1940, at 230 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1940 to Feb. 29 1940, and that I last saw her alive on Feb. 28 1940.

Immediate cause of death: Paralytic Ileus — DURATION: 14 days

Due to: Removal Ruptured Appendix — 10 Ins

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Ruptured Gangrenous Appendix
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. F. C. Snyder M. D. or other

Address: Cumberland Md. Date signed: 3-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

01334

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 410 Park St.

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 410 Park St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Infant Day

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 4, 1940

8. AGE: Years 0 Months 0 Days If less than one day 1 hrs. 0 min.

9. Birthplace Cumberland Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Berlin J. Day
13. Birthplace Elkins, West Virginia

MOTHER
14. Maiden name Katherine Youngblood
15. Birthplace Berkley Springs, W. Va.

16. Informant Berlin J. Day
Address Cumberland, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Feb 6 1940 (month) (day) (year)

~~Cemetery~~ or crematory Cremated at Stein's

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland Md.

19. Feb. 6, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1940, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4 1940, to February 4 1940, and that I last saw her alive on same date, 19

Immediate cause of death Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Schindler M.D. M. D. or other

Address 41 Grant St. Date signed February 4, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (160-a) Reg. Dist. No. 6

CERTIFICATE OF DEATH

01335

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Westernport, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:
The Reeves Clinic

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State W. Va. (b) County Mineral

(c) City or town Keyser, W. Va.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 72 Spring St.
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Baby Boy Defibaugh

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1940

8. **AGE:** Years | Months | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Westernport, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Thomas Howard Defibaugh

13. Birthplace Newburg, W. Va.

MOTHER

14. Maiden Name Beuanna Mae Kesner

15. Birthplace Pendleton Co., W. Va.

16 (a) Informant Thomas Howard Defibaugh

(b) Address Keyser, W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5 1940 (month) (day) (year)

(c) Cemetery or crematory Queen Point

Location Keyser, W. Va.

18 (a) Funeral director O. H. Markwood Son

(b) Address Keyser, W. Va

19 (a) Feb. 5 1940 (Date rec'd by registrar) (b) J. Frazier Baker M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 5, 1940 at 7 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1940, to Feb 5 1940

and that I last saw him alive on Feb 5 1940.

Immediate cause of death	Duration
Intra Cranial Hemorrhage	1 Day
Due to Immature formation of Cranial Bones	
Due to Compression at Birth	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** Norman Reeves M.D.
M. D. or other

Address Westernport, Md. Date signed 2/5/40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 4 1910
BUREAU V. S.

WITHIN CORPORATE LIMITS.

01336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 28 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: Bedford Valley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs. Ethel Deremer

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Charles Deremer

6(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): May , 1879

8. AGE: Years	Months	Days	If less than one day
60	9		hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER
12. Name: William Hite
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Emma Miller
15. Birthplace: Pennsylvania

18. Informant: Memorial Hospitsl

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17, 1940. (month) (day) (year)

Cemetery or crematory: Centreville Cem.

Location: Centreville Pa.

18. Funeral director: S. A. Barefoot.

Address: Bedford, Penna.

19. 2/14/ 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. HAWKINS

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14, 1940, at 9:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17, 1940, to Feb. 14, 1940, and that I last saw her alive on Feb. 14, 1940.

Immediate cause of death: Pyelonephritis Perhaps, Pyelophlebitis added

Due to

Due to: D.K.

Other conditions: Operation for prolapse of Ulcus
(Include pregnancy within 8 months of death)

Major findings: Of operations: Everything clean at & following operation.

Of autopsy: no

DURATION: 22 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. H. Hawkins M.D. or other

Address: Cumbd Md Date signed 2/14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (I)

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Battimore (93d) Reg. Dist. No. 4

CERTIFICATE OF DEATH

01337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 607 Greene St
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in this community (yrs., mos., or days) 12 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Greene (If rural give location)
(e) If foreign born, how long in U. S. A.? 40 years

3 (a) FULL NAME Harry M. Donnelly

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Unknown

6. (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) ✓ Unknown 1865.

8. AGE: Years	Months	Days	If less than one day
74	—	—	____ hr. ____ min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business

FATHER
12. Name Robert Donnelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Kennedy
15. Birthplace Ireland

16 (a) Informant Mrs. Ellen Kenny
(b) Address 119 Tilghman St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1940 (month) (day) (year)
(c) Cemetery or crematory Catholic Cem. Thomas W Va
Location Thomas W Va

18 (a) Funeral director Duncan Fu Parlor
(b) Address Thomas, W Va

19 (a) Feb. 23, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Feb 23 1940, at 5:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1940, to Feb 23 1940, and that I last saw him alive on Feb 21 1940

Immediate cause of death	Duration
Chronic Myocarditis	1 yr.
Due to	
Due to	
Other conditions Bronchial Asthma	yrs. ?

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. C. Bowen M.D. (M. D. or other)
Address Cumberland Md Date signed 2-23-40

RECEIVED
MAR 6 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

01338

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 15 N Waverly Terrace
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Elbin

3. (b) Social Security Number none

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1940

8. AGE: Years | Months | Days 1 | If less than one day hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Chas. R Elbin
13. Birthplace Artemas Pa.

MOTHER
14. Maiden name Ada P. Mountain
15. Birthplace Artemas Pa.

16. Informant Allegany Hosp.
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14, 1940 (month) (day) (year)

Cemetery or crematory Fairview Christian

Location Englesmith Pa.

18. Funeral director Jacob Hofer
Address Cumberland

19. Feb. 14, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 1940 to Feb 12 1940 and that I last saw him alive on Feb 11 1940

Immediate cause of death Premature birth — DURATION 6½ mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. H. Trevaskis M.D. M. D. or other

Address Cumberland Md Date signed 2/13/40

Trevaskis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

Coroner's Case

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

01339

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 hr.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Penna. County Bedford.

City or town Buffalo Mills R.D. 1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME

Mrs Hilda Louise Emerick

3. (b) Social Security Number — None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	W	Married

6 (b) Name of husband or wife Mr. Charles Emerick

6(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) May 11 1922

8. AGE:

Years	Months	Days	If less than one day
17	9	13	hrs. min.

9. Birthplace Fayett Co., Penna
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name [redacted]. A.W. Sander
13. Birthplace Hyndman, Penna.

MOTHER
14. Maiden name [redacted] Hazel Ritenour
15. Birthplace Penna.

16. Informant Mr. Charles Emerick

Address Buffalo Mills R.D. 4

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 27, 1940 (month) (day) (year)

Cemetery or crematory Palo Alto

Location Hyndman R.D. #1

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. Feb 27 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1940, at 12 a.m. 25

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw her on Feb 25 1940

Immediate cause of death Cerebral concussion and laceration - probable fracture of the skull

Due to injury, result of accident

Due to

Other conditions Shock

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Feb 24/1940

Where did injury occur? Londonderry Twp. (City or town) Bedford Co. (County) Pa (State)

Injured at home, farm, industry, public place (where?) on highway, struck by automobile, while passenger in a buggy

Means of injury automobile Injured at work? no.

23. SIGNATURE George S. Enfield M.D. M. D. or other

Address Bedford, Pa Date signed Feb 25/1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

01340

Reg. Dist. No. ____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days) 3 Days

Stay in this community (yrs., or mos., or days) ____

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Pennsylvania County Bedford

City or town Buffalo Mills Ward No. ____ (If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D.I. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME James Edward Emerick

3. (b) Social Security Number ____

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife ____

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1939

8. AGE: Years ____ Months 6 Days 10 If less than one day ____ hrs. ____ min.

9. Birthplace Buffalo Mills, Pa. R.D.I. (Town, county, and state)

10. Usual occupation ____

11. Industry or business ____

FATHER 12. Name Charles Emerick

FATHER 13. Birthplace Buffalo Mills, Pa. R.D.I.

MOTHER 14. Maiden name Hilda Sander

MOTHER 15. Birthplace Buffalo Mills, Pa. R.D.I.

16. Informant Charles Emerick

Address Buffalo Mills, Pa. R.D.I.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 29, 1940 (month) (day) (year)

Cemetery or crematory Cemetery Palo Alto

Location Hyndman, Pa. R.D.I.

18. Funeral director Harvey H. Zeuder

Address Hyndman, Pa.

19. Feb. 28 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1940, at 11 P 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1940 to Feb 27 1940, and that I last saw h[illegible] alive on Feb 27 1940.

	DURATION
Immediate cause of death: Cerebral Concussion	2/24/40 to 2/27/40
Due to: accidental fall from buggy	Feb 24 1940.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations ____

Dt autopsy ____

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2/24/40

Where did injury occur? Madley (City or town) Bedford (County) Pa. (State)

Injured at home, farm, industry, public place (where?) Side of Highway Route 96

Means of injury Automobile Struck Injured at work? Yes

23. SIGNATURE John A. Lapper M.D. M. D. or other

Address Hyndman Pa. Date signed 2/28/40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01341

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 34 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County HAMPSHIRE

City or town LEVELS Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MR. ANDREW EMMART

3. (b) Social Security Number 236-12-2886

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6 (b) Name of husband or wife UNA MILLER

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 6, 1908

8. AGE:

Years	Months	Days	If less than one day
31	8	20	hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation STORE CLERK

11. Industry or business

FATHER
12. Name MORGAN EMMART
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name MARY FLORENCE THOMAS
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28-1940 (month) (day) (year)

Cemetery or crematory Levels Cemetery

Location Levels W.Va.

18. Funeral director Thrush's.

Address Romney, W.Va.

19. Feb. 27, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 26, 1940 7:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1940 to FEB 26, 1940 and that I last saw him alive on Feb 26 1940

Immediate cause of death Septicemia Metastatic abscesses

Due to Diabetes

Due to

Other conditions Subcutaneous

(Include pregnancy within 3 months of death)

Major findings:

Of operations Subcutaneous abscesses of entire limb

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S E Enfield, M. D. or other

Address Cumberland Date signed 3/27/40

DR. ENFIELD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

01342

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 hours

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 626 Shriver Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Eppler

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

B(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): February 3, 1940

8. AGE: Years | Months | Days | If less than one day: 2 hrs. ____ min.

9. Birthplace: Memorial Hospital
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: George L. Eppler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Dorothy Eyerman (Eppler)
15. Birthplace: Maryland

1B. Informant: Memorial Hospital

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 6, 1940. (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Cumberland

1B. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Feb. 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. HODGES

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3, 1940, at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1940 to Feb. 3 1940 and that I last saw him alive on Feb. 3 1940.

Immediate cause of death: Congenital Malformations

Due to:

Due to:

Other conditions: Prematurity
(Include pregnancy within 3 months of death)

Major findings:

Of operations: Cloacal form of bladder & rectum. Club feet etc.

Of autopsy:

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: W Royce Hodges M. D. or other

Address: Cumberland, Md. Date signed: 2/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS,

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940) MD

01343

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MARYLAND (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 1 day
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County MINERAL
City or town KEYSER Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME ALLAN EVERSTINE

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife TAMSON HAINES
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 30, 187[illegible]

8. AGE: Years	Months	Days	If less than one day
67	4	5	hrs. min.

9. Birthplace MARYLAND Cumberland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Own Farm
FATHER 12. Name DANIEL M. EVERSTINE
13. Birthplace MARYLAND Cumberland
MOTHER 14. Maiden name CLARA WILLIARD
15. Birthplace MARYLAND Boonesboro
16. Informant Willard Everstine
Address Ridgley W Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 7, 1940 (month) (day) (year)
Cemetery or crematory Fort Ashby Cem
Location Fort Ashby W. Va.
18. Funeral director Jacob Dopes
Address Cumberland
19. Feb. 6 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 5, 1940 19 5:30 A.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1940, to Feb. 5 1940, and that I last saw h alive on Feb. 4 1940.

Immediate cause of death	DURATION
(a) Coronary Thrombosis	Short time
Due to (b) Arterio Sclerosis	
Due to (c) La Grippe	
Due to (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John X Williams M. D. or other
Address Cumberland Date signed 2-5-40

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01344

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Hoffman — Near Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Hoffman — Near Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: James William Dairgrieve

3. (b) Social Security Number: —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Child

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 30 1939

8. AGE:

Years	Months	Days	If less than one day
—	10	19	____ hrs. ____ min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Milton Dairgrieve
13. Birthplace: Moscow, Md.

MOTHER
14. Maiden name: Beatrice Cameron
15. Birthplace: Lonaconing, Md.

16. Informant: Milton Dairgrieve
Address: Frostburg, Md. R.F.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 21, 1940 (month) (day) (year)

Cemetery or crematory: Oak Hill

Location: Lonaconing, Md.

18. Funeral director: M. Erickson

Address: Lonaconing, Md.

19. Feb. 20 1940 (Date rec'd by registrar)

Mrs. A. R. Walker, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1940, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 1940, to Feb 19 1940, and that I last saw h— alive on Feb. 19 1940.

Immediate cause of death	DURATION
Acute gastritis	2 days
Enteritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations:

Dt autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other

Address: Lonaconing, Md. Date signed Feb 20 '40

RECEIVED
MAR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (942)

01345

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany St.
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Allegany
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Samuel Fine

3. (b) Social Security Number: —

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rachael Irwin
6(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): — — 1861

8. AGE: Years: 78 Months: — Days: — If less than one day: hrs. min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Department Store
FATHER
12. Name: Hessel Fine
13. Birthplace: Lithuania
MOTHER
14. Maiden name: Unknown
15. Birthplace: Lithuania
16. Informant: Benjamin Marx
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 13, 1940 (month) (day) (year)
Cemetery or crematory: B. & Chapin Cemetery
Location: Cumberland, Md.
18. Funeral director: Wolford Funeral Home
Address: Cumberland, Md.
19. Feb. 13 1940 (Date rec'd by registrar) L. Douglas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12 1940, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h — alive on — 19 —.
Immediate cause of death: Coronary Occlusion
Due to
Due to
Other conditions: Chronic Bronchial Asthma
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other
Address: Lonaconing, Md. Date signed: Feb. 13 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1910
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01346

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 124 Paca st

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life time

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 124 Paca st
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME John J. Fisher

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1861

8. AGE: Years 79 Months 4 Days 11 If less than one day hrs. min.

9. Birthplace Cumberland Maryland
(Town, county, and state)

10. Usual occupation Leather worker (Retired)

11. Industry or business Union Tannery

FATHER
12. Name George Fisher
13. Birthplace Germany

MOTHER
14. Maiden name Gertrude Fisher
15. Birthplace Germany

16. Informant Anna Fible

Address 124 Paca St Cumberland Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Feb. 16, 1940
(month) (day) (year)

Cemetery or crematory St Peter & Paul

Location Cumberland Md.

18. Funeral director J. L. Lempereur

Address Cumberland Md.

19. 2/15/ 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1940, at 22° M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6, 1940, to Feb 14 1940, and that I last saw him alive on Feb 6 1940.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION
7 days
2 yrs
2 yrs

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. N. Lynn M. D. or other

Address Cumberland Md Date signed Feb 16 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

01347

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 hours

Stay in this community (yrs., or mos., or days): ##hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 109 North Centre Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Ellen Frantz

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alvey M. Frantz

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1892

8. AGE: Years: 47 | Months: 5 | Days: 27 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Manns Choice, Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER 12. Name: Alfred T. Newman

FATHER 13. Birthplace: Washington, D. C.

MOTHER 14. Maiden name: Ida Rebecca Bogolf

MOTHER 15. Birthplace: Manns Choice, Penna.

16. Informant: Alfred T. Newman

Address: Manns Choice, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 14, 1940 (month) (day) (year)

Cemetery or crematory: Chestnut Ridge Cemetery

Location: Schellsburg, Pennsylvania

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Feb. 13, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12, 1940, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 1940, to Feb 12, 1940, and that I last saw h[illegible] alive on Feb. 12, 1940.

Immediate cause of death: Acute cardiac dilatation — DURATION: 3 hours

Due to: ____

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ____

Of autopsy: ____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: W. B. Barrow M.D. (M. D. or other)

Address: 122 Bedford St Date signed: 2-13-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

01348

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Schriver Hill
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 314 Waverly Terrace
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: John R. Gannon

3. (b) Social Security Number: 705-05-5947

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Gladys C. Rice
6(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): February 14, 1905

8. AGE:

Years	Months	Days	If less than one day
34	11	25	____ hrs. ____ min.

9. Birthplace: Nashville, Tenn.
(Town, county, and state)

10. Usual occupation: Machinist helper

11. Industry or business: Celenese

FATHER
12. Name: Unknown (Gray)
13. Birthplace: Unknown

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Benjamin W. Rice
Address: 484 Balto. Ave., Cumb'd, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb. 13, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11th., 1940, at about 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Strangulation by hanging.	
Due to	
Due to	
Other conditions: Dislocation of atlas--axis articulation.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 2-11-1940
Where did injury occur? Cumberland, Allegany, Maryland. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): on hill overlooking Cumberland, Md.
Means of injury: hanging Injured at work?

23. SIGNATURE: Charles H. Iverson, M.D. M. D. or other
Address: Cumberland, Maryland. Date signed: 2-12-1940

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01349

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 224 Cole St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Garlick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 25, 1940

8. AGE: Years	Months	Days	If less than one day
			hrs. 10 min.

9. Birthplace Memorial Hospital Cumberland, Md.
(City, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Ralph Garlick
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret Fisher
15. Birthplace Maryland

16. Informant Memorial Hosp.
Address Cumberland, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Feb. 25 1940 (month) (day) (year)

Cemetery or crematory Memorial Hospital
Location Same

18. Funeral director
Address

19 Feb. 27 (Date rec'd by registrar) 19 40 J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1940, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 1940, to Feb. 25 1940, and that I last saw him alive on Feb. 25 1940.

Immediate cause of death	DURATION
Prematurity (6 mo. gestation)	2-25-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arthur T. Jones M.D. M. D. or other
Address 402 N. Liberty St. Date signed 2-25-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01350

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 605 Louisiana Avenue

Stay in hospital or inst. (yrs., or mos., or days): 3 weeks

Stay in this community (yrs., or mos., or days): 35

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 605 Louisiana Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Sarah M. Garvin

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Charles F.

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 10, 1860

8. AGE: Years	Months	Days	If less than one day
79	10	4	____ hrs. ____ min.

9. Birthplace: Lancaster, Pennsylvania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER — 12. Name: George S. Chanbel

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Eliza Krieder

MOTHER — 15. Birthplace: Maryland

16. Informant: Henry R. Garvin

Address: Youngstown, Ohio

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 16, 1940 (month) (day) (year)

Cemetery or crematory: Greenwood Cemetery

Location: Lancaster, Pennsylvania

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19 Feb 16, 19 40 (Date rec'd by registrar) J. C. Mankin M.D. Registrar

Dr. Trevaskis

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 19 40 at 12 15 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 19 40 to Feb 14 19 40

and that I last saw her alive on Feb 14 19 40

Immediate cause of death	DURATION
Biliary calculi	1 year
Due to	
Due to	
Other conditions: Chronic myocarditis (Include pregnancy within 3 months of death)	1 year

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: R. R. Trevaskis M.D. M. D. or other

Address: Cumberland, Md Date signed 2/14/40

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01351

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution: Church Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 51 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL, NEAR and give town)
Street No.: Church
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Henry Richard Gillies

3. (b) Social Security Number: 164-10-3096

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Christina Cosgrove
6. (c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): September 27, 1888
8. AGE: Years: 51 Months: 4 Days: 20 If less than one day: hrs. min.
9. Birthplace: Mikep, Allegany, Maryland (Town, county, and state)
10. Usual occupation: U. S. Coal Worker
11. Industry or business: Dam
FATHER 12. Name: Alexander Gillies
FATHER 13. Birthplace: Scotland
MOTHER 14. Maiden name: Ellen Thompson
MOTHER 15. Birthplace: Scotland
16. Informant: Mrs. Henry Gillies
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 20 1940 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. Feb 19 19 40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17 1940, at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940, to Feb 17 1940, and that I last saw h[illegible] alive on Feb 17 1940.

	DURATION
Immediate cause of death: Broncho Pneumonia	
Due to	
Due to	
Other conditions: Influenza	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: Feb 19 40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01352

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 513 Louisiana Vanue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 513 Louisiana Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Cora Agnes Goddard

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Julius H. Goddard

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1853

8. AGE: Years: 86 Months: 3 Days: 3 If less than one day: hrs. min.

9. Birthplace: Worcester, Massachusetts (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Edwin Chapin
13. Birthplace: Unknown

MOTHER
14. Maiden name: Persis Earle
15. Birthplace: Unknown

16. Informant: Mrs. Kary G. Perry
Address: Cumberland, Md.

17. ~~Burial~~ Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1940 (month) (day) (year)

Cemetery or crematory:
Location: Topeka, Kansas

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Feb. 13 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12th 1940, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10th 1940, to Feb 12 1940, and that I last saw h a alive on Feb 12 1940.

Immediate cause of death: Influenza — DURATION: 3 day

Due to:

Due to: Acute Myocarditis — 2 day

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: P. L. Owens M. D.
Address: Cumberland Md M. D. or other
Date signed: Feb 13-40

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01353

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Rt. #2, Williams Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles Levi Goff

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Emily Powell Goff
6(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): June 26, 1855

8. AGE: Years	Months	Days	If less than one day
84	7	25	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Lorenzo Goff
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Parker
15. Birthplace: Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24-40 (month) (day) (year)
Cemetery or crematory: Clifton Forge, Va
Location: Clifton Forge, Va

18. Funeral director: U. L. Funderburg
Address: Cumberland, Md.

19. Feb. 23, 1940 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

DR. LANICH

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21, 1940, at 8:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1940, to Feb 21 1940, and that I last saw him alive on Feb 21 1940.

Immediate cause of death: Pneumonia (Lobar) — DURATION: ?
Due to: C
Due to: C
Other conditions: C
(Include pregnancy within 3 months of death)

Major findings:
Ot operations:
Ot autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. J. Lanich M.D.
M. D. or other
Address: Cumberland Md Date signed: 2-21-40

RECEIVED
MAR 8 1910
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46-6)

01354

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 144 Main St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) about 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 144 Main St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME John Standish Graney

3. (b) Social Security Number 213-12-9681 ~~None~~

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amelia Seymour

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.): Nov. 1. 1876

8. AGE: Years 63 | Months 3 | Days 5 | If less than one day ___ hrs. ___ min.

9. Birthplace: Piedmont W. Va. Mineral Co. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER
12. Name: John Graney
13. Birthplace: Ireland

MOTHER
14. Maiden name: Annie Flannigan
15. Birthplace: Ireland

16. Informant: Mrs. Amelia Graney

Address: 144 Main St. Westernport Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Feb 9 1940 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport

19. Funeral director: D. S. Boal

Address: Westernport Md.

19. Feb. 8 1940 (Date rec'd by registrar) A. Gaz Mbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6 1940, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1936, to Feb 6 1940, and that I last saw him alive on Feb. 6 1940.

Immediate cause of death: Generalized Carcinomatosis

Due to: Primary carcinoma of stomach. Duration: 2½ years. C.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 2 yrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P E Berry M.D. M. D. or other

Address: Piedmont Md. Date signed 2/7/40

RECEIVED
MAR 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

01355

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County: Allegany

City or town: Paw Paw Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.:

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Robert U. Grant

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 19, 1866

8. AGE: Years	Months	Days	If less than one day
73	8	8	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Retired trackman

11. Industry or business: B. & O. Railroad

FATHER — 12. Name: James Grant

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Elizabeth Deaver

MOTHER — 15. Birthplace: West Virginia

16. Informant: Mrs. Anna Holcomb

Address: Akron, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 1, 1940 (month) (day) (year)

Cemetery or crematory: Levels Cemetery

Location: Levels, West Virginia

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Feb. 29, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. Mathew

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27, 1940, to Feb 27, 1940, and that I last saw h alive on Feb 27, 1940

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

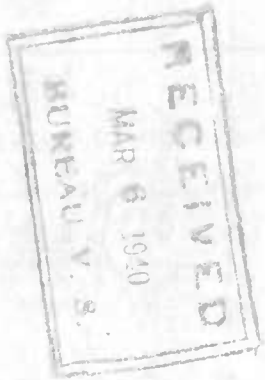
Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Date signed:

Matthews



WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01356

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 22 Greene St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 22 Greene St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Henry Gray

3. (b) Social Security Number: NONE.

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Gray

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1852

8. AGE: Years: 87 Months: 1 Days: 18 If less than one day ____ hrs. ____ min.

9. Birthplace: Sharpsburg Md.
(Town, county, and state)

10. Usual occupation: P.R.R. Employee

11. Industry or business

FATHER
12. Name: John Gray
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: George H. Winters

Address: 305 Paca St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 15, 1940 (month) (day) (year)

Cemetery or crematory: Mt. View Cemetery

Location: Sharpsburg, Md.

18. Funeral director: John C. Wolford

Address: Cumberland, Md.

19. 2/14/ 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13, 1940 19__, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 1940, to Feb. 13, 1940, and that I last saw him alive on Feb. 12, 1940.

Immediate cause of death: Acute Nephritis Laguppe.

DURATION: 8 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C. F. W. Snyder M. D. or other

Address: Cumberland Md. Date signed: 8-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

FEB 23 1940
BUREAU V. A.

Dwelling CORPORATE LIMITS.

67 N. Center

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

01357

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 207 Knox St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Joanne Grimes

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: John W. Grimes

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1864

8. AGE: Years	Months	Days	If less than one day
76	0	7	____ hrs. ____ min.

9. Birthplace: Ocean Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Daniel A. Barnard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Levenia Olise
15. Birthplace: Md.

16. Informant: Cecil A. Grimes
Address: 453 Central Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 15, 1940 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Lonoconing Md.

18. Funeral director: John C. Wolford

Address: Cumberland, Md.

19. 2/14/40 (Date rec'd by registrar) 1940 J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13 1939 40 19 ____ at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1940, to Feb 13 1940, and that I last saw her alive on Feb 12 1940.

Immediate cause of death: Cardiac weakness due to shock, fell out of bed and fractured her arm Feb 8/40

Due to: Chronic myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 4 days

?

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: J. L. V. Deming M.D. M. D. or other

Address: 67 N. Center St. Date signed: 2-14/40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01358

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 158 1/2 Bedford St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Md Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 158 1/2 Bedford St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George A. Hadra

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

B (b) Name of husband or wife Mattie E. Arendell

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1863

8. AGE: Years 76 Months 11 Days 18 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Md. (Town, county, and state)

10. Usual occupation Retired Engineer

11. Industry or business Railroad

FATHER 12. Name Edward Hadra

13. Birthplace U. S. A.

MOTHER 14. Maiden name Mary Schultz

15. Birthplace U. S. A.

16. Informant George Hadra

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. Feb. 21, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1940, at 12 15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1940, to Feb 20 1940, and that I last saw him ~~alive~~ dead on Feb 20 1940.

Immediate cause of death Uremia

Due to Chronic parenchymatous nephritis Chronic endocarditis

Due to Partial hemaplegia due

Other conditions B. Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings: Of operations Treated by Dr Koon for several years.

Of autopsy

DURATION several years 10 yrs.

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address 67 N. Center St Date signed 2/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

RECEIVED
MAR 8 1940
BUREAU V. S.

Outside of City Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01359

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Williams Road, residence

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 73 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Williams Road, residence
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: William C. Hager

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna M. Hardinger

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): September 8, 1866

8. AGE: Years 73 Months 4 Days 26 If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Stonemason

11. Industry or business: none

FATHER
12. Name: Marshall Hager
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Norman C. Hager
Address: Cumberland, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Feb. 6, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Feb. 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1940, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1940 to Feb 4 1940, and that I last saw him alive on Feb 3 1940.

Immediate cause of death: Arsenic Coma — DURATION: Feb. 1 to 4.

Due to: Chronic Nephritis — 3 yrs

Due to: Chronic Endocarditis — 3 yrs

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos. H. Kraus M. D. ~~or other~~
Address: Cumberland Md Date signed: Feb 5-40

RECEIVED
MAR 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01360

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Rd.#3 Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rd.#3 Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Bedford Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Sarah Elizabeth Hardinger

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Theodore Hardinger

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1885

8. AGE: Years	Months	Days	If less than one day
54	10	10	____ hrs. ____ min.

9. Birthplace Smithsburg, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Henry Martin

13. Birthplace Maryland

MOTHER 14. Maiden name Sarah Mentzer

15. Birthplace Maryland

16. Informant John Hardinger

Address Rd.#3. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb.19,1940 (month) (day) (year)

Cemetery or crematory Centenary Cem.

Location Bedford Road

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Feb. 18 1940 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1940, at 1A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18, 1940 to Feb. 17 1940, and that I last saw her alive on Feb. 15 1940.

Immediate cause of death	DURATION
Nasal Hemorrhage	
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles A. Gracey M. D. or other

Address Cumberland Md Date signed 2-17-40

RECEIVED
MAR 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

01361

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Uhl Highway, 3 miles east of city
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Uhl Highway, 3 miles east
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ella Heavner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Perran Heavner
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ##. January 23, 1860

8. AGE: Years	Months	Days	If less than one day
80	1	4	hrs. min.

8. Birthplace: Moorefield, W. Va. (Town, county, and state)
10. Usual occupation: Housewife
At home
11. Industry or business:
FATHER 12. Name: Shadrick Gorings
13. Birthplace: West Virginia
MOTHER 14. Maiden name: May Webster
15. Birthplace: West Virginia
16. Informant: Ed Heavner
Address: Bowling Green, near Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 1, 1940 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Moorefield, W. Va.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.
19. Feb 29 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27, 1940, at 6:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28, 1939, to Feb 27, 1940, and that I last saw h-- alive on Feb. 26, 1940.

Immediate cause of death	DURATION
Multiple Body Contusions	11/28/39
Generalized Arteriosclerosis	
Due to Chronic Hypocarditis	
Due to Uraemia	2/10/40
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy: Md.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11/28/39
Where did injury occur? Cumberland (City or town) Md. (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Fall Down Stairs Injured at work? No

23. SIGNATURE: Clay E. Jarrett, M. D. or other
Address: Cumberland, Md. Date signed: Feb. 28, 1940

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

01362

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 6 days

Stay in this community (yrs., or mos., or days) 67 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 22 N. Lee
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Helen Helman

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Percy A Helman

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 30 1873

8. AGE: Years 67 | Months — | Days 23 | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Louis Soyster
13. Birthplace Md

MOTHER
14. Maiden name Caroline Schanks
15. Birthplace Md

16. Informant Percy A Helman
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25 40 (month) (day) (year)

Cemetery or ~~crematory~~ Emmittsburg, Md

Location Emmittsburg, Md

18. Funeral director Louis Stein Inc
Address Cumberland

19. Feb. 24, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1940, at 7:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9, 1939, to Feb. 23, 1940, and that I last saw her alive on Feb. 23, 1940.

Immediate cause of death Carcinoma of spine

Due to Breasts (Carcinoma)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE C. C. [signature] M. D. or other

Address 105 S. Centre St. Cumberland Md. Date signed 2/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01363

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 29 DAYS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. REAR 910 GAY STREET
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
JAMES W. Havermill, MR.

3. (b) Social Security Number
705-09-3661

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B (b) Name of husband or wife Nora Bivans

Deceased 6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1895

8. AGE:

Years	Months	Days	If less than one day
54	1	25	hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation Brakeman

11. Industry or business B & O R.R. Co

FATHER 12. Name Havermill, MILLARD

13. Birthplace (DECEASED) West Va

MOTHER 14. Maiden name (DECEASED)

15. Birthplace Unknown

16. Informant James Havermill

Address 639 Elm St. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 6 40 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Bedford Rd. Cumberland Md.

18. Funeral director V. L. Temperens

Address Cumberland, Md

19. Feb. 6, 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. DURRETT

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 2, 19 40, at 9:20 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 10, 19 40, to Feb. 2, 19 40, and that I last saw h— alive on Feb. 2, 19 40.

Immediate cause of death Lobar Pneumonia

Cerebro-Spinal Meningitis

Due to Septicaemia

Caused by the staphylococcus aureus

Due to

Other conditions

DURATION
1/6/40
1/20/40
1/15/40

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clark Durrett M. D., or other

Address Cumberland Md. Date signed 2/4/40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48C

CERTIFICATE OF DEATH

01364

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 819 Patterson Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 819 Patterson Ave.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Hattie Iser

3. (b) Social Security Number None

4. Sex: F

5. Color or race: white

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Isaac Iser deceased

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 30, 1872

8. AGE: Years 67 | Months 3 | Days 30 | If less than one day ____ hrs. ____ min.

9. Birthplace: West Va
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: at Home

FATHER
12. Name: Geo. Harrison
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Cora Harris
15. Birthplace: W. Va.

16. Informant: Mrs Ora Darr

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28/40 (month) (day) (year)

Cemetery or crematory: Springfield W Va

Location: Springfield, W Va

18. Funeral director: V. L. Lemperour

Address: Cumberland, Md.

19. Feb. 28, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1940, at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 1940, to Feb 26 1940, and that I last saw her alive on Feb. 18 1940.

Immediate cause of death: Toxemia from Cancer of Uterus — DURATION: 2 yrs

Due to: Cancer of Uterus — 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Thos. A. Kaan M. D. or other

Address: 221 Baltimore av Date signed 2/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

01365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 426 Chestnut Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 45 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 426 Chestnut Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Clarence S. Jones

3. (b) Social Security Number: 214-05-4773

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Cecelia Becker

6(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): May 14, 1894

8. AGE:

Years	Months	Days	If less than one day
45	9	0	hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Brewery Brewing C

FATHER
12. Name: James Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia Smith
15. Birthplace: Maryland

16. Informant: James Jones (son)
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17, 1940 (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Feb. 16, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1940, at 6 49 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec - 14 1939, to Feb - 14 1940, and that I last saw him alive on Feb. 14 1940.

Immediate cause of death	DURATION
Myocarditis 93d	1939
Endocarditis 92c	1939
Due to Rheumatic fever 58c	1900
Due to	
Other conditions Labor pneumonia 108	Dec. 10 1939

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. W. Eliason M.D. M. D. or other
Address: 126 Union St. Cumberland Md. Date signed: 2/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01366

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days): 43 Days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: GARRETT
City or town: KITZMILLER Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: MRS. MARGARET JUNKINS

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife: PAUL JUNKINS
6(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): FEB. 22, 1897

8. AGE: Years	Months	Days	If less than one day
43	0	4	hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace:
MOTHER 14. Maiden name: MARY ROSS
15. Birthplace: ? Unknown
16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/29/40 (month) (day) (year)
Cemetery or crematory: Oakland Cemetery
Location: Oakland Md
18. Funeral director: O. F. Sharpless
Address: Blaine, W Va
19. Feb. 27 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB 26, 1940, at 8:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-5- 1940, to 2-26- 1940, and that I last saw her alive on 2-26 1940.

Immediate cause of death: Chronic Nephritis with Hypertension — DURATION: years?
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: none
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Howard L. Tolson M. D. or other
Address: Cumberland Date signed 2-26-40

VS A15

DR. LANIGH & DR. TOLSON

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)-P

CERTIFICATE OF DEATH

01367

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Mechanic St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Wm. Henry Kallmyer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife: Emma Lewis.

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1868

8. AGE: Years: 72 | Months: 1 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Hoffman Mines, Md. (Town, county, and state)

10. Usual occupation: Harness Maker.

11. Industry or business: Home Harness Retail

FATHER 12. Name: August Kallmyer

13. Birthplace: Germany

MOTHER 14. Maiden name: Eliza Hasselrode

15. Birthplace: Germany.

16. Informant: Wm. Kallmyer. Address: Route #1 Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21, 1940 (month) (day) (year)

Cemetery or crematory: German Lutheran

Location: Frostburg, Md.

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. 2-21 1940 (Date rec'd by registrar) Mrs. A R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18. 1940, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 1940, to Feb. 18 1940, and that I last saw h[illegible] alive on Feb. 18 1940

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs.
Due to Chronic nephritis	3 yrs.
Due to Chronic Cystitis	3 yrs.
arteria - sclerosis	3 yrs.
Due to Hypertrophy of prostate	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: Of operations: none

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Dieh, M. D. M. D. or other

Address: Frostburg, Md. Date signed: 2/20/40

RECEIVED
MAR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

01368

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (171-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 800 Columbia Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 800 Columbia Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward Dale Kirk

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1935

8. AGE: Years 4 Months 11 Days 2 If less than one day hrs. min.

9. Birthplace Cumberland
(Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Maurice Kirk
13. Birthplace Cumberland, Md

MOTHER
14. Maiden name Hattie E. Smith
15. Birthplace Cumberland, Md

16. Informant Maurice Kirk

Address 800 Columbia Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 19, 1940 (month) (day) (year)

Cemetery or crematory St. Patricks Cemetery

Location Cumberland, Md.

18. Funeral director Jacob Hafer

Address 230 Baltimore Ave.

19 Feb. 18, 1940 (Date rec'd by registrar) J. P. Mauklin, M.D. Registrar

Enfield.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw him alive on Feb 16 1940

Immediate cause of death Internal Hemorrhage

Due to Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Feb 16-40

Where did injury occur? Cumberland (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?) Neighbors yard

Means of injury Coasted into truck Injured at work?

23. SIGNATURE A. E. Enfield M. D. or other

Address Cumberland Date signed 2/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

FEB 23 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-a)

CERTIFICATE OF DEATH

01369

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: (If outside city or town limits, write RURAL NEAR and give town) Cumberland Md
Street address, hospital, or institution: Allegany Hosp
Stay in hospital or inst. (yrs., or mos., or days): 1 Mo.
Stay in this community (yrs., or mos., or days): 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: (If outside city or town limits, write RURAL NEAR and give town) Cumberland Ward No.
Street No.: Fairgo - 127 10.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mike - (Michael Koffard
3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Oct 30 - 1885
8. AGE: Years: 54 Months: 3 Days: 25 If less than one day: hrs. min.
9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Tire Worker (Retired)
11. Industry or business: Kelly - Springfield Co
FATHER 12. Name: Michael Koffard
13. Birthplace: Austria
MOTHER 14. Maiden name: Unknown
15. Birthplace: Austria
16. Informant: Andrew Koffski
Address: Cumberland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 1 - 40 (month) (day) (year)
Cemetery or crematory: Zion Memorial Park
Location: Cumberland, Md - R.F.D.
18. Funeral director: V. L. Temperance
Address: Cumberland, Md
19. March 1, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-25-40 19 , at 9:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15, 1939 to Feb. 25, 1940, and that I last saw h alive on 2-24-40 19
Immediate cause of death: Pernicious anemia — DURATION: 6 yrs ?
Due to: ?
Due to: —
Other conditions: Pulmonary hypostasis
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed: 3-1-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01370

CERTIFICATE OF DEATH

(93-d)

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1¼ hours

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Vale Summit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Miss Elizabeth Kohl

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): January ? 1859

8. AGE: Years	Months	Days	If less than one day
81	1		____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: George Kohl,
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Memorial Hospital

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 20, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg, Md.

18. Funeral director: Jacob Hofer

Address: Frostburg, Md.

19. Feb. 20, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. LANICH

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17, 1940, at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 1940, to Feb 17 1940, and that I last saw h ____ alive on ____ 19____.

Immediate cause of death: Chronic myocarditis. C.W.G.R. Duration: not stated.

Due to: Patient dead when brought in Hospital

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Samuel M. Jacobson M.D. M. D. or other

Address: 119 Bedford St. Date signed: 2/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

01371

1. PLACE OF DEATH (8)

County Allegany Registration Dist. No. 4

Village or City Cumberland No. Memorial Hosp. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Baby Girl Kronty (Stillborn)

(a) Residence: No. ..... St., ... Ward. Kitzmiller, Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Feb. 25, 1940

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.

Stillborn

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Cumberland Md. (State or country)

FATHER

13. NAME Edward Thomas Kronty

14. BIRTHPLACE (city or town) Clear spring Md. (State or country)

MOTHER

15. MAIDEN NAME Gertrude Elaine Bernard

16. BIRTHPLACE (city or town) Oakland Md. (State or country)

17. INFORMANT Memorial Hosp. (Address) Cumberland Md.

18. BURIAL, CREMATION, OR REMOVAL Destroyed at Hospital Date Feb. 25, 1940

19. UNDERTAKER (Address)

20. FILED Feb. 27, 1940 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 25 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1940, to Feb. 25, 1940

I last saw her alive on Stillborn 19 ; death is said to have occurred on the date stated above, at 3:31 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Intrauterine Asphyxia	2-25-40

Other Contributory Causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Arthur F. Jones M. D.

(Address) 40 N. Liberty St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48 f)

01372

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 54 Oak St

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 54 Oak St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mrs Rebecca J. Lamp

3. (b) Social Security Number none

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ Marion A. Lamp

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct 2 - 1884

8. AGE: Years 54 Months 4 Days 4 If less than one day ___ hrs. ___ min.

9. Birthplace West Va (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name Peter Kees

13. Birthplace West Va

MOTHER 14. Maiden name Elizabeth Kees

15. Birthplace West Va

16. Informant Marion A. Kees

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8-40 (month) (day) (year)

Cemetery or crematory Hillcrest Bur. Park

Location Cumberland, Md

18. Funeral director V. L. Lamperew

Address Cumberland, Md

19. Feb. 7 1940 (Date rec'd by registrar) Jos. P. Franklin, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 - 1940, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 15 1938, to Feb 6 1940, and that I last saw her alive on Feb 6 1940

Immediate cause of death Carcinoma of Uterus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 2½ yr

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide W Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M C B Owens M. D. or other

Address 138 Vale Date signed Feb 6 40

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

01373

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 226 Valley St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 226 Valley St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: August Henry Langer

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Martha Langer

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1869.

8. AGE: Years	Months	Days	If less than one day
70	4	13	hrs. min.

9. Birthplace: Cumberland (Town, county, and state)

10. Usual occupation: Groceryman

11. Industry or business:

FATHER 12. Name: Carl Langer

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Christine Stauch

MOTHER 15. Birthplace: Germany

16. Informant: Daniel Langer

Address: 226 Valley St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 5, 1940 (month) (day) (year)

Cemetery or crematory: German Luthern

Location: Cumberland

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Feb. 5 (Date rec'd by registrar) 1940 J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2, 1940, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1939, to Feb 2 1940, and that I last saw h[illegible] alive on June 30 1940.

Immediate cause of death: Carcinoma Prostate & Bladder — DURATION: Years

Due to: — DURATION: Months

Due to: — DURATION: Days

Other conditions: Anaemia & Cancerous cachexia — DURATION: Hours

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. Alan E. Lamm M. D. or other

Address: 41 Exam St Date signed: Feb 6 40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01374

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hosp.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R. D. #2.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Garland E. Lawrence

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Infant.

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 18, 1939

8. AGE:

Years	Months	Days	If less than one day
	1	16	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Cecil Lawrence
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maryland Fleek
15. Birthplace: Cumberland, Md.

16. Informant: James D. Fleek
Address: R. D. 2. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 5, 1940. (month) (day) (year)
Cemetery or crematory: Mt. Hermon Cem.
Location: Williams Road

18. Funeral director: J. C. Walford
Address: Cumberland Md.

19. Feb. 5, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940, to Feb 3 1940, and that I last saw h[illegible] alive on Feb 3 1940.

Immediate cause of death: Bronchopneumonia (Primary)

DURATION: 4 dy

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. R. Owens M. D. or other
Address: 133 Va. ave. Date signed: Feb 4 40

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIM

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-c)

01375

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 95 Ormond St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 95 Ormond St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emma Theresa Leahy

3. (b) Social Security Number none

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Leahy

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1877

8. AGE: Years 62 Months 11 Days 20 If less than one day hrs. min.

9. Birthplace Clarysville, Allegany, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name Andrew Patrick Thompson
13. Birthplace Clarysville

MOTHER
14. Maiden name Mary Martha Dudley
15. Birthplace Eckhart, Md

16. Informant Mrs. Agnes R. Elrick

Address 59 Ormond St - Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5, 1940 (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Hofer

Address 23 E. Main St. Frostburg, Md.

19. 2 - 5 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

Dr. Kilday

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1940, at 2:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/3 1940, to 2/3 1940, and that I last saw her alive on 2/3/40 1940.

Immediate cause of death Pulmonary Embolism

Due to

Due to

Other conditions Chronic Cardiac Disease
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Kilday M.D. M.D. or other

Address 56 W. Main St. Date signed 2/5/40

Frostburg, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 2 1949
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

01376

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 160 Polk Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 160 Polk Street (If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Hettie Catherine Lease

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 2, 1899

8. AGE: Years	Months	Days	If less than one day
40	7	2	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Frederick Lease
13. Birthplace: West, Virginia
MOTHER 14. Maiden name: Margaret Izenhouser
15. Birthplace: Pennsylvania
16. Informant: Miss Ada Lease
Address: 160 Polk Street, Cumb'd, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof February 7, 1940 (month) (day) (year)
Cemetery or crematory: Rea Vine Run Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Feb. 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1940, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 4, 1940, to Feb 4 1940, and that I last saw h alive on 1940.

Immediate cause of death: Patient dead when I arrived — DURATION
Due to: Coronary Occlusion
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Samuel A. Jacobson M.D. M. D. or other
Address: 119 Baltimore St. Date signed 2/5/40

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-2)

CERTIFICATE OF DEATH

01377

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 802 Brookfield Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Anne M. Leasure

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8 (b) Name of husband or wife: Jos. W. Leasure
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27, 1902

8. AGE: Years	Months	Days	If less than one day
37	6	25	hrs. min.

9. Birthplace: Keyser, West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: James P. Burns
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Hattie E. Keenen
15. Birthplace: West Virginia

16. Informant: Miss Margaret Burns
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 24, 1940 (month) (day) (year)
Cemetery or crematory: Sts. Peter & Paul Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb. 24, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar
Zimmerman

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21, 1940, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1938, to Feb. 21, 1940, and that I last saw her alive on Feb. 21, 1940.

Immediate cause of death: Sarcoma of foot — DURATION

Due to:

Due to:

Other conditions: Sarcoma of lungs
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Sarcoma of foot
amputation
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. A. Zimmerman M. D. or other
Address: 105 S. Centre St. Cumberland, Md. Date signed: 2/22/40

RECEIVED
MAR 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

01378

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town Little Orleans (Rural near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) Life 37 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Little Orleans, Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Nora Edna Leasure

3. (b) Social Security Number —

4. Sex F

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles Leasure

6(c) If alive, give age Do not know years

7. Birth date of deceased (mo., day, yr.) July 30, 1902

8. AGE: Years 37 Months 6 Days 27 If less than one day — hrs. — min.

9. Birthplace Little Orleans, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation None. Invalid for years

11. Industry or business —

FATHER
12. Name George O. Price
13. Birthplace Maryland

MOTHER
14. Maiden name Letitia Lee
15. Birthplace Pennsylvania

16. Informant C. A. Fletcher
Address Little Orleans Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 19, 1940 (month) (day) (year)

Cemetery or crematory Piney Plains Cemetery

Location Little Orleans, (Rural)

18. Funeral director Ephraim Smith
Address Artemas, Pa.

19. Feb 18 1940 (Date rec'd by registrar) T T Mann (Per) M E Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1940, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1940, to Feb. 17 1940, and that I last saw her alive on Feb. 15 1940.

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to	
Due to	
Other conditions Epilepsy	20 years

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. A. Watson M. D. or other
Address Little Orleans Md Date signed Feb. 18, 1940

RECEIVED
MAR 6 1940
BUREAU V. S.

01379

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-G)

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County: Allegany

City or town: Winchester Rd. RFD #5 Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Winchester Rd. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.F.D. #5 Cumberland
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Margaret Ann Lewis

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William T. Lewis

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): May 25, 1881

8. AGE: Years: 58 Months: 8 Days: 14 If less than one day: hrs. min.

9. Birthplace: Frostburg, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Thomas W. Richardson
13. Birthplace: England

MOTHER
14. Maiden name: Nancy Miller
15. Birthplace: Mineral County, W. Va.

16. Informant: William T. Lewis

Address: RFD #5 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 11, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Hofer

Address: 230 Baltimore Ave. Cumberland

19. 2/10 1940 (Date rec'd by registrar) M. G. Tunnell Registrar

Dr. Murray

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 9 1940, at 1:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 1940 to Feb 9 1940, and that I last saw him alive on Feb 7 1940.

Immediate cause of death: Cerebral Hemorrhage Left Hemiplegia — DURATION: 36 hrs

Due to: Hypertensive Heart disease — 3 years

Due to: Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: F. Alan G. Murray M.D. M. D. or other

Address: 41 Green St. Cumberland — Date signed: Feb 10 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

01380

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County Allegany

City or town Barton, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 69 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Barton, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Curry Patterson Lorshbaugh

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Philip Lorshbaugh

6(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) March 11, 1845

8. AGE: Years 74 | Months 11 | Days 13 | If less than one day ___ hrs. ___ min.

9. Birthplace Newtonards, Down, Ireland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name James Donald Patterson
13. Birthplace Ireland

MOTHER
14. Maiden name Isabella Curry
15. Birthplace Ireland

16. Informant Philip Lorshbaugh
Address Barton, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Feb. 27, 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director D. S. Boal
Address Barton, Md.

19. Feb 26 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24th 1940, at 7:00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 15, 1940, to Feb 24 1948, and that I last saw her alive on Feb 24th 1940

Immediate cause of death	DURATION
La Grippe	2.20.40
Bronchial Pneumonia	2.22.40
Due to	
Due to	
Other conditions Chr. Myocarditis Hypertension	1 yr

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Thorman Reeves, MD
M. D. or other

Address Westernport Md Date signed 2-26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01381

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town) Maryland

Street address, hospital, or institution: Allegany Hospital.

Stay in hospital or inst. (yrs., or mos., or days): 5

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: Hyndman R.D.#1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Lowery.

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE:

Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace: ~~Somerset County~~, Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Jessie Lowery

13. Birthplace: Pa.

MOTHER 14. Maiden name: Rachel Lowery

15. Birthplace: Pa.

16. Informant: Harry Smouse

Address: Stringtown. Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/40 (month) (day) (year)

Cemetery or crematory: Lakes Mill Pa

Location: Hyndman R.D. #1.

18. Funeral director: Harvey H Zeigler

Address: Hyndman Pa.

19. Feb. 9 (Date rec'd by registrar) 1940 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8th. 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2nd 1940, to Feb 8 1940, and that I last saw h alive on Feb 8 1940.

Immediate cause of death	DURATION
Broncho-pneumonia	6 days
Due to	
Due to	
Other conditions, Chronic Arteria-Sclerotic Heart Disease	

(Include pregnancy within 3 months of death)

Major findings:

D1 operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John. A. Topper. MD
M. D. or other

Address: Hyndman Pa Date signed Feb 9, 1940

RECEIVED
MAR 8 1940
BUREAU V. S

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131-a)

Reg. Dist. No. 4

01382

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 447 Goethe st
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 65 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 447 Goethe st (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Ned Hill Loy

3 (b) If veteran, name war ____

3 (c) Social Security No. 214-12-3004

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Helen Loy

6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 4/29-1874

8. AGE: Years 65 | Months 9 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Cumberland (Town, county, and state)

10. Usual occupation Painter

11. Industry or business House Painter

FATHER
12. Name Daniel Loy
13. Birthplace Frederick

MOTHER
14. Maiden Name Mollie E Kinkead
15. Birthplace Cumberland Md

16 (a) Informant Mrs Helen Loy
(b) Address 447 Goethe st city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/40 (month) (day) (year)
(c) Cemetery or crematory St Louises Cemetery
Location Cumberland Md

18 (a) Funeral director William H. Kight
(b) Address Cumberland Md

19 (a) Feb. 12 1940 (Date rec'd by registrar) by J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 9 1940, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1940, to Feb 9 1940, and that I last saw him alive on Feb 9 1940.

Immediate cause of death	Duration
Organic Heart Disease, Chronic Endocarditis	1 year
Due to Diabetes Mellitus	
Due to Chronic Endocarditis	1 year
Other conditions ?	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Thos. H. Loy M. D. or other
Address Cumberland Md Date signed Feb 10 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 6 1940
BUREAU V. S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-2)

CERTIFICATE OF DEATH

01383

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: LaVale, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: near Cumberland, Md.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: LaVale Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Near Cumberland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Edward Macbeth

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Adda V. Sowers
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1861

8. AGE: Years	Months	Days	If less than one day
78	2	22	hrs. min.

9. Birthplace: Pine Run, Indiana, Penna. (Town, county, and state)
10. Usual occupation: Salesman, Retired 8 years
11. Industry or business: Swift & Co.

FATHER
12. Name: William S. Macbeth
13. Birthplace: Indiana County, Pa.

MOTHER
14. Maiden name: Pauline Glass
15. Birthplace: Indiana County, Pa.

16. Informant: Robert B. Macbeth
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 27, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb 27, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24, 1940, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1940, to Feby 24, 1940, and that I last saw him alive on Feby 24, 1940.

Immediate cause of death	DURATION
Coronary Thrombosis	1 Hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. M. Schindler 2nd M. D. or other
Address: 44 Fremont. Date signed: July 26/40

RECEIVED
MAR 8 1940
BUREAU V. S.

Schindler

STATE OF MARYLAND—CERTIFICATE OF DEATH

01384

1. PLACE OF DEATH (93-d)

County Allegheny Registration Dist. No. 1

Village or City Little Orleans Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mann, Virginia E. If U.S. Veteran specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): W.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mann, Millard Fillmore

6. DATE OF BIRTH (month, day, and year): March 3, 1865

7. AGE: Years 84 | Months 11 | Days 3 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired—mother

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: — —

10. Date deceased last worked at this occupation (month and year): 1925

11. Total time (years) spent in this occupation: Life

12. BIRTHPLACE (city or town) (State or country): Wash. Co.

FATHER

13. NAME: Creek, John T

14. BIRTHPLACE (city or town) (State or country): Maryland

MOTHER

15. MAIDEN NAME: Norris, Rachael

16. BIRTHPLACE (city or town) (State or country): Maryland

17. INFORMANT (Address): Archie Smith, Little Orleans Md

18. BURIAL, CREMATION, OR REMOVAL

Place: Piney Plains Mt Cemetery Date: Feb 8, 1940

19. UNDERTAKER (Address): Ephraim Smith, Artemas Pa

20. FILED: Feb 7, 1940 T.T. Mann Pro M.E. Mann Dept Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 6 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1921, 19, to Feb 6, 1940

I last saw her alive on Feb 6, 1940; death is said to have occurred on the date stated above, at 8 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	about 25 yrs previous or 1915

Other Contributory Causes of Importance:

Name of operation: None Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19

Where did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? —

If so, specify

(Signed) H. L. Tabler M. D.

(Address) Hancock, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED MAR 8 1928 BUREAU OF U. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-a

01385

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 121 No. Allegany St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 121 No. Allegany
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Elizabeth Marsh

3. (b) Social Security Number: None

4. Sex: Fr.

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: T. J. Marsh

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct, 1874

8. AGE: Years 65 | Months 4 | Days | If less than one day ___ hrs. ___ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER
12. Name: Peter Wise
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Weigand
15. Birthplace: Germany

16. Informant: John Wise - Brother
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-26-40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md

18. Funeral director: V. L. Lemperer

Address: Cumberland, Md.

19. Feb. 26, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 23 1940, at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18. 1940, to Feb 23 1940, and that I last saw her alive on Feb. 22 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5 days

Due to: Arteriosclerosis — 2 yrs

Due to: Chronic Nephritis — 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Thos. H. Koon M. D. or other

Address: Cumberland, Md Date signed: Feb 24, 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

01386

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland. Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 221 Fulton St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 23 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany.
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 221 Fulton St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Christina "Fout" Martin

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Christopher C. Martin
6(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): Sept 20, 1871
8. AGE: Years 68 Months 5 Days 6 If less than one day hrs. min.
9. Birthplace: Laurel Dale, Mineral, W. Va.
(Town, county, and state)
10. Usual occupation: House work.
11. Industry or business: At Home
FATHER 12. Name: John Wm. Fout
13. Birthplace: Germany
MOTHER 14. Maiden name: Magdelene Ebert
15. Birthplace: Germany
18. Informant: Mrs Paul Pebley
Address 221 Fulton St, Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 29, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md.
18. Funeral director: Jacob Hafer
Address: Cumberland Md.
19. Feb 29 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1940, at 8:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 1940, to Feb. 26 1940, and that I last saw h[illegible] alive on Feb. 26 1940

	DURATION
Immediate cause of death: Coronary infarction	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Barrow MD
M. D. or other
Address 122 Bedford St Date signed 2/27/40

RECEIVED
MAR 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-6)

01387

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town rural near Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: National Hwy – Auto Park

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 49 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. National Hwy – Auto Park
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Asa George Martz

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Regina Billings

6(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) April 29 1890

8. AGE:

Years	Months	Days	If less than one day
49	9	7	hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Fair owner

11. Industry or business

FATHER
12. Name George H Martz
13. Birthplace Cumberland Md.

MOTHER
14. Maiden name Mary F Foghtman
15. Birthplace Cumberland Md.

16. Informant Edward P Martz

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-8-40 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Feb. 7 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1940, at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/4/40 19 , to 2/6 1940, and that I last saw him alive on 2/6/40 19

Immediate cause of death Acute cardiac failure brought on

Due to Fecal impaction and shock.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K Rozzum MD M. D. or other

Address Cumberland MD Date signed ~~2/8/40~~ 2/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01388

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegheny Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 626 Greene st.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3.(a) FULL NAME George S McKindless

3.(b) Social Security Number 214-05-8981

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6(b) Name of [redacted] or wife Emma R McKindless

6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) June 6 1879

8. AGE: Years 60 Months 8 Days 7 If less than one day ___ hrs. ___ min.

9. Birthplace Newton Hamilton Penn. (Town, county, and state)

10. Usual occupation District Director

11. Industry or business Home Friendly Ins. Co

FATHER 12. Name John A McKindless

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth McKindless

15. Birthplace Maryland

16. Informant Mrs Emma R McKindless

Address 626 Greene st

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 15. 1940 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md.

18. Funeral director V. L. Lemperenr

Address Cumberland Md.

19. 2/15/ 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1940, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 1940, to Feb. 13 1940, and that I last saw him alive on Feb. 13 1940.

Immediate cause of death Diabetic Coma

Due to Duodenal ulcer with Severe bleeding

Due to Diabetes Mellitus

Other conditions Chronic Duodenal ulcer

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 2 days; 8 days; 5 yrs; 3 yrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. N. Kaan M. D. or other

Address Cumberland Md Date signed Feb. 14 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

01389

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 10 days

Stay in this community (yrs., or mos., or days): 33 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 507 Washington Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Francis Joseph McMullen

3. (b) Social Security Number: 214-05-4894

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 10, 1906

8. AGE:

Years	Months	Days	If less than one day
33	11	5	____ hrs. ____ min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Newspaper man and Director of

11. Industry or business: Cumberland Evening and Sunday Times

FATHER
12. Name: Daniel F. McMullen
13. Birthplace: Franklin, Maryland

MOTHER
14. Maiden name: Anna M. McNamee
15. Birthplace: Maryland

16. Informant: Mrs. William E. Glick
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17, 1940 (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Feb. 16, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-15-40 19 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2, 1939 19 to 2-15-1940, and that I last saw him alive on 2-14-40 19

Immediate cause of death: Coronary embolism — DURATION: moder

Due to

Due to

Other conditions: Infected Thrombo-phlebitis of legs — 1 yr.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Date signed: 2-15-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

CERTIFICATE OF DEATH

01890

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 mo.
Stay in this community (yrs., or mos., or days): 22 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No.: 113 Virginia Ave (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James F. Mellon
3. (b) Social Security Number: 705-09-6678

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Kathryn Weamsley
6(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): April 23 - 1887
8. AGE: Years: 52 Months: 10 Days: 6 If less than one day: hrs. min.
9. Birthplace: Penna (Town, county, and state)
10. Usual occupation: Car Repairman
11. Industry or business: B & O. R. R. Co
FATHER 12. Name: Edward Mellon
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Mary McLaughlin
MOTHER 15. Birthplace: Ireland
16. Informant: Mrs. Margaret Mellon
Address: Cumberland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2 - 40 (month) (day) (year)
Cemetery or crematory: St. Peter & Paul Cem.
Location: Cumberland, Md.
18. Funeral director: V. L. Temperance
Address: Cumberland, Md.
19. Mar. 1 (Date rec'd by registrar) 19 40 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 29 19 40, at 2A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 39, to Feb. 29 19 40, and that I last saw h[illegible] alive on Feb. 29 19 40

	DURATION
Immediate cause of death: Carcinoma of Bronchus	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None (Bronchoscopy) + wedge Ca. of Bronchus
Of autopsy: None

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Royce Hodges M. D. or other
Address: Cumberland Date signed 2/29/40

RECEIVED
MAR 6 1940
BUREAU V. S.

01391

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 6 Browning

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 6 Browning
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura S. Mendenhall

3. (b) Social Security Number None.

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm. R. Mendenhall

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 10 1864

8. AGE: Years 76 Months 0 Days 26 If less than one day ____ hrs. ____ min.

8. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home.

FATHER
12. Name Samuel B Edmondson
13. Birthplace Penna.

MOTHER
14. Maiden name Mary Jane Collier
15. Birthplace W. Va.

16. Informant Wm. R. Mendenhall.
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-8-40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc.
Address Cumberland

19. Feb. 8, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February - 6 1940, at 1 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1939, to Feb - 6 1940, and that I last saw her alive on Feb - 6 1940.

Immediate cause of death Carcinoma of uterus — DURATION 1937

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Biopsy - Carcinoma

Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 26 Union St. Cumberland Date signed 2/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

01392

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Sylvan Retreat

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. ~~Sylvan Retreat~~ Westernport, Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ida Michael

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 65 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER: 12. Name: Unknown

13. Birthplace: "

MOTHER: 14. Maiden name: "

15. Birthplace: "

16. Informant: Sylvan Retreat

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 19, 1940 (month) (day) (year)

Cemetery or crematory: Allegany County Cemetery

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19 Feb. 19, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18 1940, at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1933, to Feb. 18 1940, and that I last saw her alive on Feb 14 1940.

Immediate cause of death: Arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. ~~or other~~

Address: Cumberland Date signed: 2/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01393

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 26 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett co.
City or town: Shallmar Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Milavec

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 6, 1931

8. AGE: Years	Months	Days	If less than one day
8	4	7	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: John Milavec
13. Birthplace: Austria-Hungary

MOTHER
14. Maiden name: Beulah Dillinger
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/40 (month) (day) (year)
Cemetery or crematory: Kalbaugh Cemetery
Location: Elk Garden W Va

18. Funeral director: O. F. Sharpless
Address: Blaine, W Va

19. Feb 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1940, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 1940 to Feb 13 1940, and that I last saw him alive on Feb 13 1940

Immediate cause of death	DURATION
Acute Endocarditis	Dec 30 39
Due to Acute myocarditis	Dec 30 39
Due to Acute Rheumatic fever	Dec 39
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE H. W. Eliason M.D.
M. D. or other
Address 126 Union St. Cumberland Md. Date signed 2/13/40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0) MD

01394

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. Va. County Mineral
City or town Ridgely Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.F.D. #1
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Calvin Miller

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Cristy Ann McCullough
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??? 1868

8. AGE: Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Farmer

FATHER
12. Name Miller
13. Birthplace Unknown

MOTHER
14. Maiden name Twigg
15. Birthplace Unknown

16. Informant Mrs. Stella Riffle
Address Ridgely, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6, 1940 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. Feb. 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Calvin Miller~~ 2/3/40 19 ..., at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15/39 19 to 2/3/40 19, and that I last saw h alive on 2/2/40 19.

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Chronic Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard J. Williams, M.D. M. D. or other
Address 34 Va. Ave. Date signed 2/5/40
Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

01395

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 54 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Walter Mont

3. (b) Social Security Number none

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced married.

6 (b) Name of husband or wife Louisa Mont

6(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 31 - 1857

8. AGE: Years 83 Months 10 Days 8 If less than one day ____ hrs. ____ min.

9. Birthplace Halifax Nova Scotia (Town, county, and state)

10. Usual occupation Brick worker

11. Industry or business Fire Brick Plant

FATHER 12. Name Joseph D. Mont

13. Birthplace England

MOTHER 14. Maiden name Elizabeth Dickle

15. Birthplace Halifax

16. Informant Thomas Mont

Address 553 Patterson Ave. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10 1940 (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Mt Savage Md

18. Funeral director Lampeur

Address Cumberland Md.

19. 2/9 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1940, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1939, to ~~Feb 29~~ 1940, and that I last saw him alive on Jan 29 1940

Immediate cause of death Chronic Nephritis

DURATION 2

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 2/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 2 1960
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

01396

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Alleganey

City or town Westernport,

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: County Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 70 Yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. County Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bridgett Agnes Moran

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Daniel Moran

8(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1863

8. AGE: Years 76 | Months 1 | Days 18 | If less than one day ____ hrs. ____ min.

8. Birthplace: Rowlesburg, W.Va. (Town, county, and state)

10. Usual occupation: House-wife

11. Industry or business

FATHER

12. Name: John P. Gilmore

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary Cady

15. Birthplace: Ireland

16. Informant: Regina Moran

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 40 (month) (day) (year)

Cemetery or crematory: St. Peters

Location: Westernport, Md.

18. Funeral director: D.S.Boal.

Address: Westernport, Md.

19. Feb. 5 1940 (Date rec'd by registrar) A. Gaymbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1940, at 11 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1939, to Feb 1 1940, and that I last saw her alive on Feb. 1 1940.

Immediate cause of death: Shock

Due to Fracture left hip on July 22, 1939.

Due to Fracture right hip on Jan. 24, 1940

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 3 Days; 6 Months; 1 week

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidents Date of 7-22-39 1-24-40

Where did injury occur? own home (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Fell on Floor Injured at work?

23. SIGNATURE: Paul A. Wilson, M.D. M. D. or other

Address: Piedmont, W.Va. Date signed 2-3-40

RECEIVED
MAR 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01397

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 12 Harrison St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 78 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 12 Harrison St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Michael L. Mooney

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie Fortney
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1862

8. AGE:

Years	Months	Days	If less than one day
78	1	8	hrs. min.

9. Birthplace Cumberland Md
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name John Mooney
13. Birthplace Dublin Ireland
MOTHER 14. Maiden name Amanda Clark
15. Birthplace Pa.
16. Informant John Mooney
Address Cumberland
17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb 24 40 (month) (day) (year)
Cemetery or crematory St. Peter & Paul's Cem
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland
19. Feb. 24 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1940, at 12:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1940, to Feb 23 1940, and that I last saw him alive on Feb. 21 1940

Immediate cause of death	Uremia Coma	DURATION 2 days
Due to	Chronic Nephritis	3 yrs
Due to	Chronic Endocarditis	8 yrs
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Cumberland Date signed 2-24-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 01398

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 67

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 214 Decatur Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles Mullen

3. (b) Social Security Number: 214-05-6261

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Norah A. Coleman

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 10, 1872

8. AGE: Years	Months	Days	If less than one day
67	2	15	hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Asst. Store Keeper

11. Industry or business: Savage River Dam Project

FATHER
12. Name: William T. Mullan
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Carlos
15. Birthplace: Maryland

16. Informant: Mrs. Walter F. Fisher
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 28, 1940 (month) (day) (year)

Cemetery or crematory: St. Patrick Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb. 27, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1940, at 6:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21 1940, to February 25 1940, and that I last saw him alive on February 25 1940.

	DURATION
Immediate cause of death: Complete Anuria with Uremia	4 days
Chronic Nephritis	??
Due to: Acute Hepatitis	4 days
Mitral Stenosis	??
~~Due to~~ Chronic Hypertrophic Pyrexia ~~Pelo~~	??
Other conditions: Bilateral Inguinal Hernia	?
Callaid Goitre	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Acute Hepatitis
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel H. Jacobson M.D. M. D. ~~or other~~

Address: 119 Bedford St. Date signed: 2/26/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

CERTIFICATE OF DEATH

01399

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Neder

3. (b) Social Security Number 712-16-6256 None

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

B (b) Name of husband or wife: Matilda Neder

6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Mar 15 1876

8. AGE: Years: 63 Months: 11 Days: 11 If less than one day: hrs. min.

9. Birthplace: Cumberland - Alleg - Md. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: R.R. car painter

FATHER

12. Name: Joseph Neder

13. Birthplace: Germany

MOTHER

14. Maiden name: Minnie Baker

15. Birthplace: Germany

16. Informant: George Neder

Address: Mt. Savage

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 29 1940 (month) (day) (year)

Cemetery or ~~crematory~~: St. George

Location: Mt. Savage

18. Funeral director: J. J. Dunn

Address: Frostburg Md.

19. 2/27 1940 H. J. Bostetter M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1940, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1937 to Feb 27 1940 and that I last saw h~~im~~ alive on Feb 26 1940,

Immediate cause of death: Cirrhosis of Liver

DURATION: 2 yrs

Due to: Arterio Sclerosis

Due to

Other conditions: Myocardial Insufficiency, Edema of Lungs

DURATION: 1 day

(Include pregnancy within 3 months of death)

Major findings:

20. operations

20. autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 2/27/40

RECEIVED
MAR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01400

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 159 N. MECHANIC ST.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME ~~Patricia Ann~~
BABY GIRL PATTON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	NEW BORN (PREMATURE)

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 18, 1940 10:10 P.M.

8. AGE:

Years	Months	Days	If less than one day
			3 hrs. 50 min.

9. Birthplace CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name EARL J. PATTON
13. Birthplace Del.

MOTHER
14. Maiden name KATHERINE FISHER
15. Birthplace ALLEGANY Co. Md.

16. Informant EARL J. PATTON

Address 159 N. MECHANIC ST., CUMBERLAND, MD.

17. Burial Date thereof Feb. 20, 1940.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Feb. 20 1940 J. P. Franklin, M.D.
(Date rec'd by Registrar) DAVE REYNOLDS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 19, 1940 19 at 2;00 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1940, to Feb 19 1940, and that I last saw her alive on Feb 19 1940.

Immediate cause of death Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Knight Reynolds M.D.
M. D. or other

Address Cumberland Md. Date Feb 19/40

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-d

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

01401

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
WITHIN CORPORATE
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 10 W. Lod St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Casper Pfeiffer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

8 (b) Name of husband or wife: Laura Pfeiffer
6(c) If wife, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March 22, 1866

8. AGE:

Years	Months	Days	If less than one day
73	11	6	hrs. min.

9. Birthplace: Eckhart, Md.
(Town, county, and state)

10. Usual occupation: Dentist

11. Industry or business

FATHER
12. Name: John Pfeiffer
13. Birthplace: Germany

MOTHER
14. Maiden name: Martha Wenck
15. Birthplace: Germany

16. Informant: Mrs Foster Reed
Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 29-1940 (month) (day) (year)
Cemetery ~~or crematory~~: Rose Hill
Location: Cumberland Md.

18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. Feb. 28th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 1940, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1940, to Feb 27 1940, and that I last saw h~~im~~ alive on Feb 27 1940.

Immediate cause of death: Carcinoma of rectum — DURATION: indefinite months

Due to:

Due to:

Other conditions: Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J R Coke M. D. or other
Address: Frostburg, Md Date signed: Feb 28 40

RECEIVED
MAR 2 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01402

1. PLACE OF DEATH (92d)

County Allegany Registration Dist. No. 1

Village or City Old Town No. RFD 1 St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. If of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Ella Piper If U. S. Veteran, specify WAR no

(a) Residence: No. Old Town Md. RFD. 1 St., Ward. no

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Piper

6. DATE OF BIRTH (month, day, and year) ?

7. AGE Years 60 Months Days If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housework

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. own home

10. Date deceased last worked at this occupation (month and year) ___ f1. Total time (years) spent in this occupation ___

12. BIRTHPLACE (city or town) (State or country) Old Town Md

FATHER

13. NAME George Hamilton

f4. BIRTHPLACE (city or town) (State or country) Old Town Md

MOTHER

15. MAIDEN NAME Jane McGuire

f6. BIRTHPLACE (city or town) (State or country) P.

f7. INFORMANT (Address) Louis Piper Old Town

18. BURIAL, CREMATION, OR REMOVAL Place Oldtown M Cemetery Date Feb 18, 1940

19. UNDERTAKER (Address) Walter Hausrote attendant B-1 Paw Paw, W. Va.

20. FILED Feb 16, 1940 Mrs C. A. Shanholtz Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February (Month) 16 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1937, to Feb 16, 1940

I last saw her alive on Feb 10, 1940; death is said to have occurred on the date stated above, at 6 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arterio sclerosis	1936
	4 yrs.

Other Contributory Causes of importance: Valvular heart Molecule

Name of operation ___ Date of ___

What test confirmed diagnosis? Clinical Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? no Date of injury ___, f9 ___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury no

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) M. G. B. Owens M. D.

(Address) 33 Va Ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01403

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart (If outside city or town limits, write RURAL NEAR and give town)

Street address, No., or location:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Eckhart Natl. Highway
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: David A. Pugh

3. (b) Social Security Number: 213-09-6483

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

B (b) Name of husband or wife: Elizabeth Pugh

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Oct. 25 - 1874

8. AGE:

Years	Months	Days	If less than one day
65	3	23	hrs. min.

9. Birthplace: Barton, Alleg. Md.
(Town, county, and state)

10. Usual occupation: coal miner

11. Industry or business:

FATHER
12. Name: Richard Pugh
13. Birthplace: Wales

MOTHER
14. Maiden name: Ann McCrosey
15. Birthplace: England

16. Informant: Richard Pugh
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 20 - 1940 (month) (day) (year)

Cemetery or crematory: Eckhart

Location: Eckhart, Md.

18. Funeral director: J. L. Dent

Address: Frostburg Md.

19. 2 - 19 - 1940 (Date rec'd by registrar)

mrs. A. R. Trader Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 1940, at 5 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mary. Feb 12 1940, to Saturday Feb 17 1940, and that I last saw him alive on Feb 17 1940

Immediate cause of death: Heart failure — DURATION: sudden

Due to: Anthracosis and grippe — DURATION: 7 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J R Cooley M. D. or other

Address: Frostburg, Maryland Date signed: Feb 19 - 1940

RECEIVED
MAR 2 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

01404

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R.F.D. #1 Opp. Cash Valley Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) no years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #1 Opp. Cash Valley Road (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry Richard Radcliffe

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Pearl Hinebaugh Radcliffe

6(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) August 8, 1898

8. AGE: Years	Months	Days	If less than one day
41	6	11	hrs. min.

9. Birthplace Vale Summit, Allegany, Maryland (Town, county, and state)

10. Usual occupation Deputy Sheriff

11. Industry or business

FATHER 12. Name Joseph Radcliffe

13. Birthplace Vale Summit Md

MOTHER 14. Maiden name Eva B. Long

15. Birthplace Palo Alto, Pa.

16. Informant Mrs. Pearl Radcliffe

Address R.F.D. #1 Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 22, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md

16. Funeral director Jack Hofer

Address 130 Baltimore Ave,

19 Feb. 21, 19 40 J.P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19th 19 40, at 4.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
accidental gun shot wound of head	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-19-1940

Where did injury occur? Cumberland, Allegany Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury gun shot Injured at work? no

23. SIGNATURE James H. Gordon, M.D. M. D. or other

Address Cumberland, Md. Date signed 2/20/1940

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

014059

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rural
Borden mines

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Borden mines Ward No. Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Frostburg Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Margret Rankin

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Robert Rankin

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 9 - 1873

8. AGE: Years: 66 Months: 7 Days: 28 If less than one day: hrs. min.

9. Birthplace: Frostburg - alleg. Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: Home

FATHER 12. Name: Thomas Davis

FATHER 13. Birthplace: ~~Scotland~~ Wales

MOTHER 14. Maiden name: Minnie Yeager

MOTHER 15. Birthplace: Borden mines Md.

16. Informant: Ennis Rankin

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 7-1940 (month) (day) (year)

Cemetery or ~~crematory~~: allegany

Location: Frostburg

18. Funeral director: J. F. Dunn

Address: Frostburg

19. Feb. 7th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1940, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30 1940, to Feb. 4 1940; and that I last saw h e r alive on Feb. 4 1940.

	DURATION
Immediate cause of death: Chronic myocarditis	4 yrs.
Due to: arterio sclerosis	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wae due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other

Address: Frostburg, Md. Date signed: 2/6/40

RECEIVED
MAR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 174

Reg. Dist. No. 9

01406

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Midlothian, Md (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miner's Hospital on arrival 1 hr. dead

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Midlothian (If outside city or town limits, write RURAL and give town) Rural

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jess Clinton Reed.

3 (b) If veteran, name war —

3 (c) Social Security No. 208-03-7181

4. Sex Male

5. Color or race white

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~ Married

6 (b) Name of husband or wife Maria Williams

6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) June 14, 1888

8. AGE: Years 51 Months 7 Days 18 If less than one day hr. min.

9. Birthplace Cleveland, Pa. (Town, county, and state)

10. Usual occupation Coal Miner.

11. Industry or business Coal Mines.

FATHER 12. Name Joseph Reed

13. Birthplace Pa.

MOTHER 14. Maiden Name Hannah Zimmerman

15. Birthplace Pa.

16 (a) Informant Mrs. Mana Reed

(b) Address Midlothian, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1940. (month) (day) (year)

(c) Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg, Maryland.

19 (a) Feb. 3rd 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 1 1940, at 10 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw him alive on 19.

Immediate cause of death Fractured skull Fractured ribs

Duration Instant

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence Feb. 1, 1940.

(c) Where did injury occur? Midlothian (City or town) Allegany (County) Md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Mine (Coal) (Specify type of place) While at work? Yes.

(e) Means of injury Rock fell on him.

23. Signature W. E. Gattens M.D. M. D. or other

Address Frostburg, Md. Date signed 2/3/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

(M)

(I)

RECEIVED
MAR 2 1940
BUREAU V. S.

01407

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: near McCoole, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R.F.D. #3 Keyser, W.Va.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: near McCoole Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

xxx Street No. R.F.D. #3 Keyser, W.Va.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: James Edward Rembold

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Cora Savilla Rembold

6(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1874

8. AGE:

Years	Months	Days	If less than one day
65	2	18	hrs. min.

9. Birthplace: Horseshoe Run, Preston Co., W.Va.
(Town, county, and state)

10. Usual occupation: retired Lumber Mill

11. Industry or business: Worker

FATHER
12. Name: Joseph Rembold
13. Birthplace: Pocahuntas, Pa.

MOTHER
14. Maiden name: Do not know
15. Birthplace:

16. Informant: L.G. Rembold

Address: R.F.D. #3 Keyser, W.Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2/25/40 (month) (day) (year)

Cemetery or crematory: Queen's Point

Location: Keyser, W.Va.

18. Funeral director: J.H. Markwood Sons

Address: Keyser, W.Va.

19. Feb. 24 1940 (Date rec'd by registrar) A.J. Sapenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-23 1940, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1931, to Feb 23 1940, and that I last saw him alive on Feb 22 1940.

Immediate cause of death: Cerebral hemorrhage. Hemiplegia left side

Due to: arteriosclerosis

Due to: First cerebral hemorrhage, October, 1933; Second cerebral hemorrhage, February 22nd, 1940. C.W.G.R.

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of:

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): none

Means of injury: none Injured at work?

23. SIGNATURE: J.C. Giffin M.D. M. D. or other

Address: Keyser W.Va. Date signed: 2-24-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

RECEIVED
MAR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

01408

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Eckhart Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie Rephann

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frederick Rephann

6(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) May 28, 1866

8. AGE: Years 73 | Months 9 | Days 3 | If less than one day ____ hrs. ____ min.

9. Birthplace Lonaconing, Maryland (Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

FATHER 12. Name John Price

FATHER 13. Birthplace Wales

MOTHER 14. Maiden name Margaret Atkinson

MOTHER 15. Birthplace Scotland

16. Informant Victor Rephann, Address Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 3 '40 (month) (day) (year)

Cemetery or crematory Eckhart cemetery,

Location Eckhart, Md.

18. Funeral director J. J. Dierst,

Address Frostburg Md.

19. 3-3 (Date rec'd by registrar) 19 40 mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 19 40, at 5 1/2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1932 19__, to Feb 29 19 40, and that I last saw h-er alive on Feb 29 19 40.

Immediate cause of death Chr Myocarditis — DURATION 8 yrs

Due to —

Due to —

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. O. Lane Jr. M.D. M. D. or other

Address Frostburg Md. Date signed Mar 2 40

RECEIVED
APR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CB

01409

157-2

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 2 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town BURLINGTON Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME

BABY CHARLES LESTER RIGGLEMAN

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 17, 1940

8. AGE: Years | Months 6 | Days | If less than one day hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name JAMES B. RIGGLEMAN
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name AMANDA MOYERS
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. BURIAL Date thereof 2/24/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LAYMANSVILLE

Location LAYMANSVILLE W.VA.

18. Funeral director EARL THRASH

Address PETERSBURG W.VA.

19. 2/22/40 19 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1940, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1940, to Feb 22 1940, and that I last saw him alive on Feb 22 1940.

Immediate cause of death Aplastic anemia

Due to Icterus Gravidarum

Due to

Other conditions Congenital Endocarditis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION
few wks
6 mos

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D.
M. D. or other

Address Cumberland Md Date signed Feb 22-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M C I T

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

CERTIFICATE OF DEATH

01410

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
87 Henderson Blvd.

Stay in hospital or inst. (yrs., or mos., or days) Dead when brought into Allegany Hospital

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 87 Henderson Blvd.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Stanley Virgil Rose

3. (b) Social Security Number 217-10-4036

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: single

8 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 15 1915

8. AGE: Years 24 Months 4 Days 4 If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business

FATHER 12. Name James Rose

13. Birthplace Va-

MOTHER 14. Maiden name Elizabeth Boliniger

15. Birthplace West Va-

16. Informant Mrs Alma Clark

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 22 1940 (month) (day) (year)

Cemetery or crematory Greenmount

Location Cumberland, md

18. Funeral director Louis Strain Inc

Address Cumberland Md

19 Feb 21 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 19 1940, to Feb 19 1940, and that I last saw him alive on Feb 19 1940. Died

	DURATION
Immediate cause of death: Acute dilatation of the heart	4 days
Due to Acute myocarditis	1 month
Due to Treated by Dr Snyder for about one month, he heard a mitral murmur about one month ago.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address 67 N. Centre St Date signed 2-20-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

01411

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 912 Piedmont Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 912 Piedmont Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sally Runion

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Addison Runion

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1871

8. AGE: Years 68 Months 11 Days 11 If less than one day hrs. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Rachel Bolo
15. Birthplace W. Va

16. Informant Mary Runion

Address Cumberland

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof 2-6-40
(month) (day) (year)

Cemetery or crematory Fort Ashby Cem.

Location Fort Ashby W. Va.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Feb. 6, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1940, to Feb 3 1940, and that I last saw her alive on 19

Immediate cause of death Cerebral apoplexy — DURATION 2 days

Due to Arterio Sclerosis — 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury Injured at work?

23. SIGNATURE M E B Owens
M. D. or other

Address 133 Va Date signed 2-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

Eleason

01412

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 15 S. Centre St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town 15 S. Center Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Cumberland
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Mary Catherine Ruppert

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Unknown

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1860

8. AGE: Years	Months	Days	If less than one day
79	9	4	hrs. min.

9. Birthplace McCoole, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henry Hughes
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Maher
15. Birthplace Ireland

16. Informant Mrs. Cora Cage

Address 15 S. Center St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 19, 1940 (month) (day) (year)

Cemetery or crematory St. Patricks

Location Cumberland

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Feb. 18, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1940, at 1P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17 1940, to Feb. 17 1940, and that I last saw her alive on Feb. 17 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	1937
Due to Arteriosclerosis	1930
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. O. Eleason M.D. M.D. or other

Address 126 Union St. Cumberland Md. Date signed 2/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

01413

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 12 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Allegany.

City or town: Cumberland, Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Allegany Grove, R.F.D.#1,
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Edith Ryan

3. (b) Social Security Number: 217-10-4512

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband: Irvin B. Ryan

6(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): March 17, 1910

8. AGE: Years	Months	Days	If less than one day
29	11	0	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Celenese

11. Industry or business:

FATHER — 12. Name: Simon Folk

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Cline

15. Birthplace: Maryland.

16. Informant: Miss Mary Folk

Address: Ridgely, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 20, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery
Cumberland, Md.

Location:

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Feb. 20, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB. 17, 1940 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6, 1940, to FEB. 17, 1940, and that I last saw her alive on FEB. 17, 1940

Immediate cause of death	DURATION
Cerebral Embolism	3 Minutes
Due to: D.H.	
Due to: Ruption for abpudiu	
Other conditions: Ruptured Ectopic Gestation (Include pregnancy within 3 months of death)	

Major findings: Ect. Appd. Bi Corneal Uterus - Perfectly Clear

Of operations:

Of autopsy: No

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. H. Hawkins, M. D. or other

Address: Cumberland, Md. Date signed: 2-18-40

RECEIVED
MAR 8 1940
BUREAU U. S.

01414

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Woodland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 38 yrs. 7 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural, Near Frostburg, Md. Ward No. — (If outside city or town limits, write RURAL NEAR and give town)

Street No. — (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: John Henry Schell

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Muncie Schell

6(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1861

8. AGE: Years: 78 Months: 4 Days: 28 If less than one day: ___ hrs. ___ min.

9. Birthplace: Hoffman, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER

12. Name: William Schell

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: Mr. Wm. Schell

Address: Frostburg, Md, R.F.D.I.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Feb 10 1940 (Date rec'd by registrar) Doris Taylor M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1940, at 5.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1940, to Feb. 5 1940, and that I last saw him alive on Feb. 5 1940.

Immediate cause of death: Coronary Occlusion

Due to: Rheumatism Endocarditis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M. D. ~~or other~~

Address: Midland, Md Date signed: 2-9-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-8

CERTIFICATE OF DEATH

01415

Reg. Dist. No. 7-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Barton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Ernest Schramm

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma Porter Schramm

6(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1879

8. AGE:

Years	Months	Days	If less than one day
60	2		hrs. min.

9. Birthplace Barton, Allegany, Md.
(Town, county, and state)

10. Usual occupation Restaurant & Saloon Keeper

11. Industry or business Garage

FATHER 12. Name Henry Schramm

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Doneger

15. Birthplace Germany.

16. Informant Julius Schramm

Address Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 17, 1940 (month) (day) (year)

Cemetery or crematory Shiloh Cemetery

Location Westernport, Md

18. Funeral director D. S. Boal

Address Barton, Md.

19. Feb. 16 1940 (Date rec'd by registrar) S. A. Bowman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14th 1940, at 1.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1940, to Feb. 14 1940, and that I last saw h[illegible] alive on Feb. 14 1940

Immediate cause of death Carcinoma of throat — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other

Address Lonaconing, Md. Date signed Feb. 15 1940

RECEIVED
MAR 15 1950
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-8)

CERTIFICATE OF DEATH

01416

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 929 Glenwood Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 61 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 929 Glenwood Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: David Allen Scott

3. (b) Social Security Number: 705-05-4800

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Alice Shipley
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 7, 1879

8. AGE: Years	Months	Days	If less than one day
61	1	1	hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)
10. Usual occupation: Machinist Helper
11. Industry or business: B. & O. Railroad
FATHER 12. Name: John Scott
13. Birthplace: Maryland
MOTHER 14. Maiden name: Susan Whorl
15. Birthplace: Maryland
16. Informant: Mr. Floyd Scott
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 11, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Feb. 10, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1940, to Feb 8 1940, and that I last saw h- alive on Feb 8 1940

Immediate cause of death	DURATION
Cerebral embolism	2 days
Due to	
Due to	
Other conditions: Arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings:
DI operations:
DI autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. R. Trevaskis M. D. or other
Address: Cumberland, Md Date signed: 2/8/40

FEB 21 1940
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35)

CERTIFICATE OF DEATH

01417

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Vale Summit

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Vale Summit Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Christina Scott

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 8 1936

8. AGE: Years: 3 Months: 3 Days: 16 If less than one day: hrs. min.

9. Birthplace: Vale Summit - Alleg - Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Perry Scott

13. Birthplace: Vale Summit, Md.

MOTHER — 14. Maiden name: Eleanor M. Loar

15. Birthplace: Lonaconing, Md.

16. Informant: Perry Scott

Address: Vale Summit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb - 24 - 1940 (month) (day) (year)

Cemetery or crematory: Vale Summit

Location: Vale Summit, Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. Feb. 24 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24 1940, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 1940 to Feb. 24 1940, and that I last saw h e alive on Feb. 24 1940

Immediate cause of death	DURATION
Circulatory Collapse	1 hr.
Due to Measles	12 hrs.
Due to Cold	2 wks.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. D. Gatting M. D. or other

Address: Frostburg, Md. Date signed 2/24/40.

RECEIVED
MAR 2 1940
BUREAU V. S.

01418

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Midland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Back Street

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 82 yrs. - 3 mos. 13 das

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Back Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Roseann Robertson Shearer

3. (b) Social Security Number: —

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: David Shearer

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 22, 1857

8. AGE: Years: 82 Months: 3 Days: 13 If less than one day: hrs. min.

9. Birthplace: Midland, Allegany Co. Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: George Robertson
13. Birthplace: Scotland

MOTHER
14. Maiden name: — Robertson
15. Birthplace: Scotland

16. Informant: Mr. George Shearer

Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Prostburg, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Feb. 7 1940 (Date rec'd by registrar) E. Doe Tay Co. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5th 1940, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 1940, to Feb 5 1940, and that I last saw her alive on Feb 5th 1940.

Immediate cause of death: Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing Md Date signed: Feb 7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

01419

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, Md. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reeves' Clinic

Stay in hospital or inst. (yrs., or mos., or days): 8 days

Stay in this community (yrs., or mos., or days): 65 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport, Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 159 Wood Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Sigler

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mellie Fletcher Sigler

6(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Jan 3 1859

8. AGE: Years: 81 Months: 1 Days: 3 If less than one day: hrs. min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Railroad supervisor

11. Industry or business: C. & P. R.R.

FATHER
12. Name: Evan J. Sigler
13. Birthplace: Unknown

MOTHER
14. Maiden name: Elizabeth Chaney
15. Birthplace: Near Frostburg, Md.

16. Informant: Mrs. John Sigler

Address: 159 Wood Street, Westernport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 9, 1940 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: D. S. Boal

Address: Barton, Md.

19. Feb. 8 1940 J. Gaynbaker M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 6th 1940, at 11:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1940, to Feb. 6 1940, and that I last saw him alive on Feb. 6 1940.

Immediate cause of death: Broncho-Pneumonia, Tonsilitis + Laryngitis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: 2 Days, 3 Days

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. E. Berry M.D. (M. D. or other)

Address: Piedmont W. Va. Date signed: 2-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (15)

Reg. Dist. No. 9

CERTIFICATE OF DEATH

01420

1. PLACE OF DEATH:
(a) County Allegany.
(b) City or town Frostburg
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miners Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in this community (yrs., mos., or days) 1

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany.
(c) City or town Frostburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) If foreign born, how long in U. S. A.? —years

3 (a) **FULL NAME** Baby Sluss.

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/40.

8. **AGE:** Years | Months | Days | If less than one day: 10 hr. ____ min.

9. Birthplace Frostburg Md.
(Town, county and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Edward Adolph Sluss.
13. Birthplace Accau, Md.

MOTHER
14. Maiden Name Harriet Willy Hart.
15. Birthplace Accau Md.

16 (a) Informant E. A. Sluss
(b) Address 118 Maple St. Frostburg Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 8 - 1940 (month) (day) (year)
(c) Cemetery or crematory Private Lot
Location Frostburg Md.

18 (a) Funeral director Edward Adolph Sluss
(b) Address Frostburg, Md.

19 (a) Feb. 6 de 40 (Date rec'd by registrar) (b) mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death 2/6/1940, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/1940, to 2/6/1940; and that I last saw him alive on 2/6/1940.

Immediate cause of death	Duration
Premature	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature W. C. Gatten M.D.
(M.D. or other)
Address Frostburg, Md. Date signed 2/7/40.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 2 1949
BUREAU OF S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

01421

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 427 South St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Girl Smith

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): February 27, 1940

8. AGE: Years: 1 day | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Smith, William K.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Edith Hahn
15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland, Md.

17. Cremated (Burial, cremation, or removal. Which?) Date thereof: Feb. 28, 1940 (month) (day) (year)

Cemetery or crematory: Memorial Hosp.

Location: Cumberland,

18. Funeral director: "

Address: "

19. Feb. 29, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. R. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28, 1940, at 10:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1940, to Feb 28 1940 and that I last saw her alive on Feb 28, 40 19

Immediate cause of death: Pre maturity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Richard J. Williams, M.D. M. D. or other

Address: 34 Van Ave. Cumberland, Md. Date signed: 3/4/40

RECEIVED
MAR 8 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01422

(53)

1. PLACE OF DEATH

County Allegany Registration Dist. No. 1

Village or City Piney Grove No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME George Elmer Smith

(a) Residence: No. ___ St., ___ Ward. ___

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a. If married, widowad, or divorced HUSBAND of (or) WIFE of ___

6. DATE OF BIRTH (month, day, and yaar) Feb. 21

7. AGE Years 77 Months 11 Days 13 If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired farmer

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc. ___

10. Data dacaased last worked at this occupation (month and year) June 1927

11. Total time (years) spent in this occupation adult life

12. BIRTHPLACE (city or town) Bedford County. (State or country) Pennsylvania

FATHER

13. NAME Solomon Smith

14. BIRTHPLACE (city or town) Bedford County (State or country) Pennsylvania

MOTHER

15. MAIDEN NAME Hannah Northcraft

16. BIRTHPLACE (city or town) Bedford County (State or country) Pennsylvania

17. INFORMANT Mary E. Watson (Address) Little Orleans, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Fairview Cemetery Data Feb. 5, 1940

19. UNDERTAKER Ephraim Smith (Addrass) Artemas, Pa.

20. FILED Feb. 6, 1940 T. T. Mann Per M E Mann Dept Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 3 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended daceased from Jan., 1939, to Feb. 3, 1940

I last saw him alive on Feb. 3, 1940; daath is said to have occurrad on the date stated above, at 10 P. m.

The PRINCIPAL CAUSE OF DEATH and ralatad causes of importanca were as follows:

	Date of onset
Cancer of Face	Oct. 1938

Other Contributory Causes of Importance:

Name of operation ___ Data of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causas (VIOLENCE) fill in also the following:

Accident, suicida, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Spacify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disaase or Injury in any way related to occupation of dacaased? No

If so, specify ___

(Signed) J. A. Watson M. D.

(Address) Little Orleans, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

(T)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED MAR 8 1940 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

01423

9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 3 hours
Stay in this community (yrs., or mos., or days): All her life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 39 East St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lenna M. Smith

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	Married

6 (b) Name of husband or wife: Charles Smith

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 10 1872

8. AGE:

Years	Months	Days	If less than one day
67	6	—	hrs. min.

9. Birthplace: Frostburg (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER
12. Name: David Taylor
13. Birthplace: Atlanta Ga.

MOTHER
14. Maiden name: Maria Ross
15. Birthplace: Baston Md.

16. Informant: Oleane Wife
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-40 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg

18. Funeral director: J. J. Hunt
Address: J. Frostburg

19. 2-14 (Date rec'd by registrar) 1940 Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1940, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1940 to Feb. 10 1940, and that I last saw h alive on Feb. 10 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 hrs.
Due to Hypertension	?
Due to Arterio-sclerosis	?
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other
Address: Frostburg, Md. Date signed 2/13/40.

RECEIVED
MAR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS,

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

01424

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 11 Altamont Terrace
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Forman E. Smith

3. (b) Social Security Number: 220-10-0080

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Mary Witt
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 12, 1891

8. AGE: Years	Months	Days	If less than one day
48	2	17	hrs. min.

9. Birthplace: Somerset County, Pennsylvania
(Town, county, and state)
10. Usual occupation: Spinning Department
11. Industry or business: Celenese

FATHER
12. Name: Jacob Smith
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Ranker
15. Birthplace: Pennsylvania

18. Informant: Mrs. S. M. Cozad
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 11, 1940 (month) (day) (year)
Cemetery or crematory: Greenmont Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Feb. 10, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8, 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1940, to Feb 8, 1940, and that I last saw him alive on Feb. 8, 1940.

Immediate cause of death	DURATION
Bronchial Pneumonia	1 week
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W B Barron M.D.
M. D. or other
Address: 122 Bedford St Date signed: 2-9-40

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

01425

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or insf. (yrs., or mos., or days): 2½ hours

Stay in this community (yrs., or mos., or days): 8 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Natural Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near Frostburg (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Albert Barnes Somerville

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 26, 1870.

8. AGE: Years: 69 | Months: 4 | Days: 15 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Barton, Allegany County, Md. (Town, county, and state)

10. Usual occupation: Retired - Clerk

11. Industry or business: Coal Mine

FATHER — f2. Name: John Somerville

FATHER — f3. Birthplace: Scotland

MOTHER — 14. Maiden name: Agnes Russell

MOTHER — f5. Birthplace: Scotland

16. Informant: William M. L. Somerville

Address: Cumberland, Md.

f7. Burial (Burial, cremation, or removal. Which?) Date thereof February 14, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Maryland

18. Funeral director: M. Eichhorn

Address: Lonaconing, Maryland

19. Feb. 13, 1940 (Date rec'd by registrar) J. P. Hawkins, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11 1940, at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from On Feb 11 1940, to — 19—, and that I last saw him alive on Feb. 11 1940.

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to Post operative Strangulated Hernia.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: R. M. Shelton Jr M. D. (M. D. or other)

Address: Midland, Md. Date signed: Feb 13, 1940

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (200-C)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

01426 9

Reg. Dist. No. ____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 101 Charles St
Stay in hospital or inst. (yrs., or mos., or deys): ____
Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg Md Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 101 Charles St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME: Baby Boy Sperry

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife: Infant
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 29 1940

8. AGE: Years ____ Months ____ Days 25 If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: ____

FATHER
12. Name: Clay Sperry
13. Birthplace: Meyersdale Pa

MOTHER
14. Maiden name: Virginia Shank
15. Birthplace: McCoole Md

16. Informant: Clay Sperry
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23, 1940 (month) (day) (year)
Cemetery or crematory: Indian Mound
Location: Romney W. Va.

18. Funeral director: Jacob Hofer
Address: Frostburg Md.

19. Feb. 23 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 1940, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 1940 to Feb 22 1940, and that I last saw him alive on Feb 5 1940.

	DURATION
Immediate cause of death: Found dead in crib; no evidence of suffocation. Cause unknown.	
Due to: Natural Causes	
Due to (or as a consequence of): Child was full term, normal infant. No birth injury. No evidence of suffocation. Cause U.K.	
Other conditions: Found dead in crib; cause, unknown.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ____
Of autopsy: ____

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Wm C. Lane Jr MD
M. D. or other
Address: Frostburg Md Date signed: Feb 23 '40

RECEIVED
MAR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

01427

Reg. Dist. No. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cresaptown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cresaptown Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward Carl Spiker

3. (b) Social Security Number 220-10-2194

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Catherine Hollenback

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1883.

8. AGE: Years 56 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation Pipe Worker

11. Industry or business Savage River Dam

FATHER 12. Name Henry Spiker

13. Birthplace Maryland

MOTHER 14. Maiden name Isabelle Frazerbaker

15. Birthplace Fairmont Rock Near Westernport

16. Informant Jacob Spiker

Address Houston, Pennsylvania

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15, 1940 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

16. Funeral director M. Eichhorn

Address Lonaconing Md

19. Feb 14, 1940 (Date rec'd by registrar) W. Yaman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1940, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1939, to Jan 10 1940, and that I last saw him alive on Jan 10 1940.

	Cause	Interval between onset and death
Immediate cause of death	Intestinal obstruction	?
Due to	Adeno Carcinoma Caecum	
Due to	Colotomy performed	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations Obstructing carcinoma Caecum 12-12-39

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson Jr. M. D. or other

Address Cumberland Md Date signed 2-14-40

RECEIVED
MAR 5 1910
BUREAU U. S.

Outside of [redacted] City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01428

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: La Vale
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 14 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rockeser Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. La Vale (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME John Adam Sperl

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Agatha Martin
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1868

8. AGE:

Years	Months	Days	If less than one day
71	5		hrs. min.

9. Birthplace Cumberland Md. (Town, county, and state)
10. Usual occupation Machinist (Retired 8 yrs.
11. Industry or business Celanese
12. Name of FATHER Geo W. Sperl
13. Birthplace of FATHER Germany
14. Maiden name of MOTHER Elizabeth —
15. Birthplace of MOTHER Germany
16. Informant Mrs Clifton Harper
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-40 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Mrs. Stein Inc.
Address Cumberland Md
19. Feb. 4 (Date rec'd by registrar) 1940 J. H. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1940, at 8:35 P.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from January 23 1940, to February 1 1940, and that I last saw h[illegible] alive on January 31 1940.

Immediate cause of death Myocarditis — DURATION 5 years
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE James T. Johnson Jr. M. D. or other
Address Cumberland, Md Date signed 2-2-40

RECEIVED
MAR 8 1948
BUREAU V. S.

Outside of City Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01429

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural Near Spring Gap
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 24 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Spring Gap Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #1 Oldtown, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Raymond Stallings

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Ella Alice Estella Stallings

6(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1875

8. AGE:

Years	Months	Days	If less than one day
65	0	19	hrs. min.

9. Birthplace Near Oldtown, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own farm

FATHER
12. Name Norman A Stallings
13. Birthplace Twiggtown, Md

MOTHER
14. Maiden name Susanne Twigg
15. Birthplace Twiggtown, Md.

16. Informant Ella Alice Estella Stallings
Address R.F.D. #1 Oldtown, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Feb 16, 1940
(month) (day) (year)

Cemetery or crematory Mt. Tabor Cemetery

Location Spring Gap, Md.

18. Funeral director Jacob Hofer

Address 230 Baltimore Ave.

19. Feb. 16 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Durette

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11, 1940, to Feb. 16, 1940, and that I last saw him alive on Feb. 11, 1940.

Immediate cause of death Lobar Pneumonia — DURATION 2/7/40

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clary E. Durrett
M. D. or other

Address Cumberland, Md Date signed 2/15/40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01430

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 212 New Hampshire Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Miss Lorena M. Stump

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B (b) Name of husband or wife: None
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22 - 1868

8. AGE: Years	Months	Days	If less than one day
71	10	0	hrs. min.

9. Birthplace: ? West Va (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: John W. Stump
13. Birthplace: West Va
MOTHER 14. Maiden name: Rhoda Catlett
15. Birthplace: West Va
16. Informant: Memorial Hospital
Address: Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 24-40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: U. L. Lemperouse
Address: Cumberland, Md.
19 Feb 23, 1940 J. L. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22, 1940 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 1940 to Feb 22 1940 and that I last saw h er alive on Feb 22 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 day
Due to Hypertension & Chr Nephritis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Lanich M.D. M. D. or other
Address: Cumberland Md Date signed 2-24-40

DR. LANICH

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(108)

01431

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or insf. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Locust Grove (Rt. 1 Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mr. Perry Theodore Tipton

3. (b) Social Security Number 220-07-6882

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1905

8. AGE: Years 35 Months 3 Days 7 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Unable to work

11. Industry or business Had been glass worker

FATHER 12. Name George Tipton

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Nettie Leach

15. Birthplace Pennsylvania

16. Informant Mrs. Myrtle Thrasher

Address Locust Grove, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 21, 1940 (month) (day) (year)

Cemetery or crematory Old Lonoconing Cem

Location Knapps Meadow, Md.

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19. Feb. 20, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1940, at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/18/40 19 to 2/18/40 19, and that I last saw h in alive on 2/18/40 19

Immediate cause of death Lobar Pneumonia.

Duration: One week. [illegible]

Due to Pneumococcus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Williams M. D. or other

Address 34 Va. Ave. Cumberland Md. Date signed 2/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

(T)

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

01432

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Waterdiffe

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Waterdiffe

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Frost

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Verner Frost

13. Birthplace Maryland

MOTHER 14. Maiden name Helen P. Phillips

15. Birthplace Lonaconing Md.

16. Informant Verner Frost

Address Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 20 1940 (month) (day) (year)

Cemetery or crematory Old Coney Cemetery

Location Lonaconing Md.

18. Funeral director Mr. Eichhorn

Address Lonaconing Md.

19. Feb 20 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1940, at 1030 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,

and that I last saw him alive on Feb 19 1940

Immediate cause of death	DURATION
Accidentally suffocated while in bed with mother.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry W. Hodgson M.D.

M. D. or other

Address Lonaconing, Md. Date signed Feb 20 1940

CEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01433

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 16 S. Mechanic Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 66 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 16 S. Mechanic St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Welty Troxell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1873

8. AGE: Years	Months	Days	If less than one day
66	9	19	hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Retired tinner

11. Industry or business

FATHER
12. Name Solomon Troxell
13. Birthplace Maryland

MOTHER
14. Maiden name Catherine Welty
15. Birthplace Illinois

16. Informant Miss Minnie Troxell
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 26k 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. Feb. 26, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. Demming

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1940, at about 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1940, to Feb 23 1940, and that I last saw him alive on Feb 23 1940.

Immediate cause of death Uremia

Due to Chronic parenchymatous nephritis

Due to Chronic myocarditis

Other conditions Treated for heart condition over one year ago by Dr. T. Koon
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: Several years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address 67 N. Center St. Date signed Feb 24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01434

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ~~Allegany~~ Allegany
City or town ~~Cumberland~~ Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: ~~Allegany Hospital~~ Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ~~Maryland~~ Ohio County ~~Allegany~~
City or town ~~Cumberland~~ Canton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ~~Allegany Hospital~~ Barris R.F.D.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ethel M. Turner

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1940

8. AGE:

Years	Months	Days	If less than one day
			3 hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Joseph Turner
13. Birthplace Mt. Pleasant, Ohio

MOTHER
14. Maiden name Iris Hemphill
15. Birthplace Tarentum, Penna.

16. Informant Allegany Hospital
Address Cumberland, Md.

17. ~~Burial~~ Cremation Date thereof Feb. 22, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Stein's Funeral Home
Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19 Feb. 22 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Dr. Arthur Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1940, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 1940, to Feb. 21 1940, and that I last saw her alive on Feb. 21 1940.

Immediate cause of death	DURATION
Prematurity (6 mo. Gestation)	2-21-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arthur T. Jones M.D.
M. D. or other
Address 40 N. Liberty St. Date signed 2-21-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01435

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Windsor Hotel Lobby

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Mt. Savage
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mervin Uhl

3. (b) Social Security Number 215-10-2283

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie Garey

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.): March 10, 1893

8. AGE: Years 46 | Months 11 | Days 1 | If less than one day ___ hrs. ___ min.

9. Birthplace: Mt. Savage, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Cement

FATHER
12. Name: Richard Uhl
13. Birthplace: Mt. Savage, Md.

MOTHER
14. Maiden name: Alice Holtzman
15. Birthplace: Mt. Savage, Md.

16. Informant: Mrs. Katie G. Uhl
Address: Mt. Savage, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-1940 (month) (day) (year)

Cemetery or ~~crematory~~ Mt Savage

Location Mt. Savage, Md.

18. Funeral director J. J. Dwyer

Address Frostburg Md.

19. Feb. 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11th., 1940, at 10.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis H. Corson, M.D. M. D. or other

Address Cumberland, Maryland Date signed 2-12-40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

01436

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Presumably
County Allegany
City or town Found on Mt. Savage Road. (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: near Cumberland, Md.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State County
City or town Unknown Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Foetus (male, about 7 months.)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	-----

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace W. Cumberland, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden name
15. Birthplace

16. Informant Investigation by County Investigator.
Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Feb. 27, 1940 (month) (day) (year)
Cemetery or crematory Kafer's Funeral Home
Location Cumberland, Md.

18. Funeral director Jacob Kafer
Address Cumberland, Md.

19. Feb. 27, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION unknown

20. DATE OF DEATH Probably February 23rd, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,
and that I last saw h alive on 19.

Immediate cause of death	DURATION
Probably abortion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Probably abortion Date of unknown
Where did injury occur? unknown (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) unknown
Means of injury Injured at work?

23. SIGNATURE Samuel H. Isaacson, M.D.
Cumberland, Maryland M. D. or other
Address Date signed 2/25/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

01437

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 333 Bedford Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 333 Bedford Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Jane McVicker Valentine

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George P. Valentine

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) October 6, 1853

8. AGE: Years 86 Months 4 Days 4 If less than one day ____ hrs. ____ min.

9. Birthplace Bedford County, Penna.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Athome

FATHER 12. Name James McVicker

13. Birthplace Unknown

MOTHER 14. Maiden name Amelia Fleegle

15. Birthplace Unknown

16. Informant Clarence B. Valentine

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 12, 1940 (month) (day) (year)

Cemetery or crematory St. Luke Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Feb. 12, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. Hoon.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1940 19____, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1940, to Feb. 10 1940, and that I last saw her alive on Feb. 10 1940.

Immediate cause of death Uremic Coma

Due to Chronic Nephritis

Due to Chronic Endocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 24 hours; 3 yrs; 3 yrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. Hoon M. D. or other

Address Cumberland Md Date signed Feb 10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01438

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Pekin

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ~

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 15 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Pekin Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. ~

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ~

3. (a) FULL NAME Margaret Louise Vinci

3. (b) Social Security Number ~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	child

6 (b) Name of husband or wife ~

6(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Feb. 24. 1940

8. AGE: Years ~ | Months ~ | Days ~ | If less than one day 15 hrs. ~ min.

9. Birthplace Pekin, Allegany, Md (Town, county, and state)

10. Usual occupation none

11. Industry or business ~

FATHER 12. Name Thomas Vinci

13. Birthplace Burrell, W Va

MOTHER 14. Maiden name Margaret S Taylor

15. Birthplace Lonaconing, Md

16. Informant Mrs Phillip Vinci

Address Pekin, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 25, 40 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemtery

Location Morrow, Md

18. Funeral director M. Eichhorn

Address Lonaconing Md

19. Feb 25 1940 (Date rec'd by registrar) Dru Taylor M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1940, at 930 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1940, to Feb 24 1940, and that I last saw h- alive on Feb 24 1940.

	DURATION
Immediate cause of death Premature birth	12 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D. M. D. or other

Address Lonaconing Md Date signed 7-25-40

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

01439 5

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa County Bedford
City or town Everett Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Harvey Welch
3. (b) Social Security Number None

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced widowed
6 (b) Name of husband or wife Emma Weist
died at 67 6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 16-1869
8. AGE: Years 70 Months 8 Days 27 If less than one day hrs. min.
9. Birthplace Fulton Co Pa (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Nathan Welch
13. Birthplace Penna
MOTHER 14. Maiden name — Buzzard
15. Birthplace Penna.
16. Informant Chas. Sereth
Address Cresaptown, Md
17. Burial and Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 16, 1940 (month) (day) (year)
Cemetery or crematory Grace Ville Cem
Location Graceville, Penna
18. Funeral director Ballantyne
Address Everett Pa
19. Feb. 14, 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1940, at 3 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1939, to Feb 13 1940, and that I last saw him alive on Feb 12 1940.

Immediate cause of death Pulmonary Oedema — DURATION 5 to 6 hrs
Due to Chronic Bronchitis Bronchial asthma
Due to
Other conditions Chronic Myocarditis Chronic Nephritis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. Alan G. Hennessy Md M.D. or other
Address 41 Green St Date signed Feb 14 1940
Cumberland Md

VS A15 (I) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01440

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Enroute to Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 214 Wallace St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Williams

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M.	Negro	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 26, 1940

8. AGE: Years: Still born | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Lester A. Williams

FATHER 13. Birthplace: Frostburg, Maryland

MOTHER 14. Maiden name: Ruth Catherine Jones

MOTHER 15. Birthplace: Shipman, Virginia

16. Informant: Lester A. Williams

Address: 214 Wallace Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 26, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cem

Location: Frostburg, Md.

18. Funeral director: Lester A. Williams Parent

Address: 214 Wallace St., City

19. Feb. 26, 1940 (Date rec'd by registrar) J. C. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 26, 1940, at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25, 1940, to Feb 26, 1940, and that I last saw h alive on Feb 26, 1940.

Immediate cause of death	DURATION
Still born premature infant	
Due to 4 month	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Cyple R. Everhart M.D.
M. D. or other

Address: 36 Greene St Date signed: 2/26-40

RECEIVED
MAR 6 1940
BUREAU F. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (92a)

Reg. Dist. No. 4 ✓

01441

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Windsor Road The Dingle
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 70 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. Windsor Road The Dingle (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME James Bradley Williams

3 (b) If veteran, name war

3 (c) Social Security No. ~~None~~ 214-12-0686 Ross

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ~~Adella Williams~~

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1870

8. AGE: Years 70 Months 0 Days 26 If less than one day ____ hr. ____ min.

9. Birthplace Cumberland (Town, county, and state)

10. Usual occupation Foundry Operator

11. Industry or business Machine Foundry

FATHER
12. Name James B. Williams
13. Birthplace Dont Know

MOTHER
14. Maiden Name Sophia Filler
15. Birthplace Ramsburg Pa

16 (a) Informant Paul A. Williams
(b) Address The Dingle City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/40 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Cumberland

18 (a) Funeral director Wm H. Kight
(b) Address Cumberland Md

19 (a) Feb 16, 1940 (Date rec'd by registrar) (b) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death 2/14 1940, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1940, to Feb 14 1940, and that I last saw him alive on Feb 14 1940.

Immediate cause of death Acute Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D. or other

Address 122 S O Center Date signed

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 9 1910
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01442

Reg. Dist. No. 8

1. PLACE OF DEATH:
County Allegany
City or town Midland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 4 mos. 9 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Maryland County Allegany
City or town Midland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rada E. Plummer Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John H. Williams
6(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1887

8. AGE:

Years	Months	Days	If less than one day
52	6	3	hrs. min.

9. Birthplace New Shaft, Allegany Co., Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home

FATHER
12. Name Thomas Plummer
13. Birthplace Maryland

MOTHER
14. Maiden name Barbara Loar
15. Birthplace Maryland.

16. Informant Mrs. Thos. Stevens
Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 24, 1940 (month) (day) (year)
Cemetery or crematory Hill Crest Cemetery
Location Cumberland, Md.

18. Funeral director C. A. Eichhorn
Address Lonaconing, Md.

19. Feb 24 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1940, at 9:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ Dec Feb. 20 1940, to 19
and that I last saw h er alive on Feb 20 1940

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Rheumatic Endocarditis?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. M. Shelton Jr. M D.
M. D. or other
Address Midland, Md. Date signed 2-23-40

RECEIVED
MAR 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

01443

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 109 Race Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 84 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 109 Race Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Emma E. Wilson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B (b) Name of husband or wife: Jerome R. Wilson
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10, 1855

8. AGE: Years	Months	Days	If less than one day
84	9	14	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: J. H. Kight
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mr. C. M. Wilson
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 26, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem
Location: Cumberland, Md.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb. 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. Richard D. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/24/40 19 , at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/10/40 19 , to 2/24/40 19 , and that I last saw h alive on 2/23/40 19

Immediate cause of death	DURATION
Chronic Myocarditis	
General Debility	
Due to Old Age.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard D. Williams M.D. M. D. or other
Address: 34 Van Ave., Date signed: 2-24-40

RECEIVED
MAR 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

01444

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 301 Pennsylvania Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Raymond Victor Zollner.

3. (b) Social Security Number: 705-07-8665

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

B (b) Name of husband or wife: Irene J. Hauser

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 24, 1887

8. AGE: Years: 52 Months: 7 Days: 1 If less than one day ____ hrs. ____ min.

9. Birthplace: Magnolia, W. Va.
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: B. & O. Railroad

FATHER
12. Name: George Zollner
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Agnes Dyche
15. Birthplace: West Virginia

18. Informant: Melvin Zollner
Address: Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Feb. 28, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb. 27, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25th, 1940, at 11.45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 1940, to Feb 25 1940, and that I last saw him alive on Feb 20 1940.

Immediate cause of death: Ruptured Gangrenous Appendix & Peritonitis — DURATION: 12 days

Due to

Due to

Other conditions: Hypostatic Pneumonia — 4 days
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

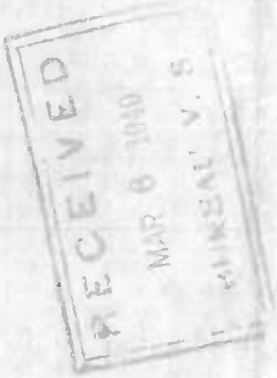
PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: R. C. Bowen M.D. M. D. or other
Address: Cumberland Md. Date signed: 2-26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Bowen